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UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF TEXAS

— — —

THE HONORABLE GEORGE C. HANKS, JR., JUDGE PRESIDING

USA, No. 4:21-CR-00009-1

Plaintiff,

vs.

ROBERT T. BROCKMAN,

ORIGINAL

Defendant.

COMPETENCY HEARING -- DAY 1 AM SESSION

OFFICIAL REPORTER'S TRANSCRIPT OF PROCEEDINGS

Houston, Texas

MONDAY, NOVEMBER 15, 2021

APPEARANCES:

For the Plaintiff: COREY J. SMITH, DOJ

CHRISTOPHER MAGNANI, DOJ

LEE F. LANGSTON, DOJ

BORIS BOURGET, DOJ

For the Defendant: JASON S. VARNADO, ESQ., Attorney  
at Law

COLLEEN O' CONNOR, ESQ.,  
Attorney at Law

JAMES P. LOONAM, ESQ., Attorney  
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For the  
Interpreter: n/a

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## EXHIBITS MARKED ON BEHALF OF THE DEFENSE

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NUMBER	DESCRIPTION	MARKED	RECEIVED	WITHDRAWN
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SEAN W. GUMM, CSR #13168, RPR, CRR

## PROCEEDINGS

(The following proceedings held in open court.)

\* \* \*

**MONDAY, NOVEMBER 15, 2021 -- 9:16 A.M.**

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THE COURT: Good morning, everyone.

The first case, and the only case on the Court's Docket is Cause 4:21-CR-00009-1, the United States of America versus Robert T. Brockman. Before we get started and the introductions, I just wanted to tell the parties sort of my rules with respect to masks. When you are addressing the Court, please feel free to take your masks off, or when you are cross-examining the witnesses please feel free to take your masks off.

Members of the audience, I respectfully request that you keep your masks on at all times if you are not addressing the Court. I know it's a little crowded. You can't really social distance in here. We're going to see if there's a lot of people for tomorrow, possibly if the electronics works out maybe getting a bigger courtroom to use, but if everything's the way it is today then I think we're okay.

09:16:39 1 If the parties can introduce  
09:16:41 2 themselves and state the parties they represent,  
09:16:43 3 starting with the Government.

09:16:44 4 MR. COREY SMITH: Good morning, Your  
09:16:45 5 Honor. Corey Smith on behalf of the United States.  
09:16:47 6 With me are my colleagues Lee Langston, Boris  
09:16:50 7 Bourget, and Chris Magnani.

09:16:53 8 THE COURT: Good morning.

09:16:56 9 MR. COREY SMITH: Also have our case  
09:16:57 10 agent sitting at counsel table.

09:16:58 11 THE COURT: Welcome, sir.

09:16:59 12 On behalf of Mr. Brockman?

09:17:01 13 MR. VARNADO: Yes, good morning, Your  
09:17:02 14 Honor. Jason Varnado on behalf of Mr. Brockman, and  
09:17:06 15 with my colleagues James Loonam, Kathy Keneally, and  
09:17:09 16 of course Mr. Brockman is here as well.

09:17:10 17 THE COURT: Welcome, Mr. Brockman.

09:17:13 18 MR. VARNADO: We have some other  
09:17:14 19 colleagues before openings, but I'll do that for  
09:17:16 20 now.

09:17:16 21 THE COURT: Not a problem. First of  
09:17:18 22 all, is good to see you all in person after so long.  
09:17:22 23 It's been awhile so...

09:17:23 24 Before we get started, I know the  
09:17:25 25 parties have a couple of issues they wanted to raise

09:17:27 1 with the Court, and then I've got a couple of issues  
09:17:30 2 I wanted to talk to you about. But before we get  
09:17:33 3 started, first did you get a chance to exchange  
09:17:36 4 witness lists and talk about who is going to be  
09:17:38 5 called today?

09:17:39 6 MR. COREY SMITH: Yes, we've done that,  
09:17:40 7 Your Honor.

09:17:40 8 THE COURT: Okay. Great. Can you all  
09:17:42 9 just begin with whatever issues you have and then  
09:17:45 10 we'll talk about my issues?

09:17:47 11 MR. COREY SMITH: Sure, Your Honor. We  
09:17:49 12 have three items we want to bring up with the Court  
09:17:51 13 before we get started. We have, as the Court  
09:17:53 14 instructed, stipulated as to a number of exhibits  
09:17:56 15 that are going to be pre-admitted, and we can go  
09:17:58 16 through the respective parties' pre-admitted  
09:18:01 17 exhibits.

09:18:01 18 The second issue is there's this --  
09:18:03 19 we've discussed sequestration of witnesses, and we  
09:18:06 20 need to address that. I believe the Defense wants  
09:18:09 21 sequestration rule and details there, and we'd like  
09:18:12 22 to address that with the Court.

09:18:13 23 Third issue is a particular witness  
09:18:14 24 that was actually a witness for the Government,  
09:18:17 25 Dr. Maria Ponisio. The Defense now has subpoenaed

09:18:20 1 her, and there's some scheduling issues that are  
09:18:22 2 kind of urgent and we wanted to bring that up with  
09:18:25 3 the Court.

09:18:25 4 THE COURT: Okay.

09:18:27 5 MR. VARNADO: Your Honor, there may be  
09:18:28 6 one -- additional information concerning information  
09:18:31 7 we received from the Government last night with  
09:18:33 8 respect to a witness they intend to call this  
09:18:35 9 morning. Mr. Loonam will address that this morning.

09:18:38 10 THE COURT: Okay. Great. Before we  
09:18:40 11 get started then, let's go ahead and if you could on  
09:18:42 12 the record tell me which exhibits that you would  
09:18:45 13 like to pre-admit, and then we'll get those on the  
09:18:48 14 record from both sides. Then we'll talk about  
09:18:51 15 sequestration next.

09:18:53 16 So let's start with the  
09:18:54 17 Government's exhibits, all of the exhibits that the  
09:18:57 18 parties agree to admit, from the Government.

09:19:00 19 MR. COREY SMITH: The parties have  
09:19:01 20 agreed that the Government's exhibit list to  
09:19:03 21 pre-admit Exhibits 1 through 5, 28 through 27 [SIC],  
09:19:07 22 and 81 through 96.

09:19:11 23 THE COURT: Okay. Those exhibits are  
09:19:14 24 admitted.

09:19:15 25 MR. VARNADO: Your Honor, there may be

09:19:16 1 a little...

09:19:17 2 THE COURT: Okay.

09:19:25 3 MR. COREY SMITH: Sorry, Your Honor.

09:19:27 4 That's right we filed this one. There's a slight  
09:19:29 5 change, if I can correct the record?

09:19:31 6 THE COURT: Okay.

09:19:31 7 MR. COREY SMITH: Government's  
09:19:33 8 Exhibits 1 through 8, 29, 32 through 43, 58 through  
09:19:41 9 60, 77 through 95 were pre-admitted. Then there's  
09:19:53 10 additional exhibits that the parties have agreed to  
09:19:57 11 that -- there's additional exhibits that the parties  
09:20:03 12 have agreed to that are -- that the parties agree  
09:20:06 13 are authentic. That's Government's Exhibit 9  
09:20:09 14 through 27, 44 through 57, 62 through 75 and 97  
09:20:19 15 through 114.

09:20:20 16 THE COURT: Okay.

09:20:22 17 MR. VARNADO: Your Honor, on that last  
09:20:23 18 batch of exhibits, we did come to an agreement with  
09:20:25 19 the Government. We're not contesting authenticity.  
09:20:28 20 We're just preserving our right to object to the  
09:20:30 21 evidence being not relevant or cumulative, but tried  
09:20:32 22 to work out everything we could so people aren't  
09:20:34 23 having to lay a foundation and take the Court's  
09:20:36 24 time.

09:20:37 25 THE COURT: That's perfect. So those

09:20:38 1 exhibits are not admitted, but basically there's no  
09:20:42 2 objection to the authenticity of those?

09:20:45 3 MR. VARNADO: That's correct, Your  
09:20:46 4 Honor.

09:20:46 5 THE COURT: Those documents.

09:20:47 6 MR. VARNADO: For the pre-admitted for  
09:20:49 7 the Defense, Your Honor, it's just Exhibits 1  
09:20:50 8 through 48.

09:20:51 9 THE COURT: Okay. Great. Those  
09:20:54 10 exhibits 1 through 48, and then the exhibits  
09:20:56 11 identified by the Government as pre-admitted are now  
09:21:00 12 pre-admitted.

09:21:03 13 Okay. Now, let's talk about the  
09:21:04 14 sequestration of the witnesses.

09:21:08 15 MR. VARNADO: Your Honor, I think the  
09:21:09 16 Government has asked that we would consent to their  
09:21:12 17 three experts remaining in the courtroom for the  
09:21:15 18 entirety of the proceedings and observing all of the  
09:21:18 19 cross-examinations.

09:21:20 20 In fact, as represented that one of  
09:21:21 21 their witnesses they intend to have is a summary  
09:21:24 22 expert witness. We object to the Defense -- I mean  
09:21:27 23 the Government's experts remaining in the courtroom  
09:21:30 24 for the entirety of the proceeding.

09:21:32 25 First, the Defense experts -- our

09:21:35 1 experts are treating physicians. They have  
09:21:37 2 patients. They have a very narrow window of time  
09:21:40 3 that they're going to be able to attend this time,  
09:21:42 4 as opposed to the Government's experts, which are  
09:21:45 5 expert testifiers and be here this whole time.

09:21:48 6 Second, there is disagreement among  
09:21:51 7 the Government's experts. They've got one expert  
09:21:53 8 who says they can't decide if Mr. Brockman is  
09:21:56 9 competent or not. They have another expert that is  
09:21:58 10 steadfast and says that Mr. Brockman is malingering.

09:22:02 11 And they have a third expert who  
09:22:03 12 said Mr. Brockman was competent, and then said he  
09:22:05 13 couldn't decide, and then came back with a different  
09:22:08 14 opinion and comes back and says he is competent.

09:22:10 15 We believe because there's daylight  
09:22:13 16 between these experts, they should not be allowed to  
09:22:15 17 remain in the courtroom and observe the  
09:22:16 18 cross-examinations of the other experts. We think  
09:22:18 19 that's an unfair process, and we ask that the expert  
09:22:22 20 witnesses be sequestered for this particular  
09:22:24 21 hearing.

09:22:25 22 THE COURT: Okay. That's very unusual.  
09:22:27 23 Experts are always allowed -- I mean, in my  
09:22:30 24 experience -- to hear the testimony of other experts  
09:22:33 25 and testify -- testify based on what they hear. Is

09:22:37 1 there any reason why -- I guess you are saying in  
09:22:41 2 this case because their testimony differs so much  
09:22:45 3 that they shouldn't be allowed to hear other experts  
09:22:48 4 items? I'm not quite sure I understand.

09:22:51 5 MR. VARNADO: I'll be clear. We don't  
09:22:52 6 object to after they testify if they're going to  
09:22:54 7 remain in the courtroom, but we don't think they  
09:22:58 8 should be able to observe the expert before them who  
09:23:00 9 is testifying to be cross-examined, and educate  
09:23:02 10 themselves so they can address their testimony in a  
09:23:05 11 different way.

09:23:06 12 So I do think that is what we're  
09:23:08 13 asking, not to prohibit them from after -- you know,  
09:23:11 14 leave the witness stand from remaining in the  
09:23:13 15 courtroom if that's their choice and what they want  
09:23:15 16 to do, but for an expert to sit here and observe all  
09:23:18 17 of the testimony and essentially form new opinions  
09:23:20 18 that are not part of their expert reports, that's  
09:23:23 19 something we're objecting to.

09:23:24 20 THE COURT: But that's typical.  
09:23:26 21 Experts can listen to other experts' testimony, and  
09:23:29 22 then provide supplemental testimony based on what  
09:23:33 23 they hear in Court. So respectfully, the motion is  
09:23:36 24 overruled.

09:23:36 25 MR. VARNADO: Okay. Thank you, Your

09:23:37 1 Honor.

09:23:37 2 THE COURT: But if you guys do want to  
09:23:39 3 invoke the rule, I'll invoke the rule as to fact  
09:23:42 4 witnesses, but with respect to experts, experts are  
09:23:44 5 allowed to stay in the courtroom and hear the  
09:23:46 6 testimony.

09:23:48 7 MR. COREY SMITH: We do agree to invoke  
09:23:50 8 the rule with fact witnesses, with one exception. I  
09:23:54 9 guess that's the attorney for Mr. Brockman, Kathy  
09:23:57 10 Keneally. I guess she's going to testify -- since  
09:23:59 11 she's lead counsel, we don't object to her staying  
09:24:01 12 in the courtroom.

09:24:02 13 THE COURT: Okay.

09:24:03 14 MR. VARNADO: Mr. Smith -- we had  
09:24:04 15 talked about Mr. Brockman's caretaker,  
09:24:07 16 Mr. Gutierrez. He may very well testify as well and  
09:24:10 17 the Government indicated they did not object to him  
09:24:12 18 remaining.

09:24:13 19 MR. COREY SMITH: That's correct, Your  
09:24:14 20 Honor. We don't object to Mr. Brockman's caretaker  
09:24:18 21 staying in the courtroom.

09:24:19 22 THE COURT: So the rule has been  
09:24:20 23 invoked. Anyone that's in the courtroom that's  
09:24:22 24 going to be providing fact testimony needs to excuse  
09:24:26 25 themselves, and then we can call them back.

09:24:28 1 Is there anyone you want me to  
09:24:30 2 swear in to make sure they appear later on that are  
09:24:33 3 appearing by subpoena?

09:24:35 4 MR. VARNADO: No, Your Honor.

09:24:36 5 MR. COREY SMITH: No.

09:24:36 6 THE COURT: Okay. Then if you are in  
09:24:38 7 the courtroom, ladies and gentlemen, and you are a  
09:24:39 8 fact witness and not an expert, or Mr. Brockman's  
09:24:43 9 caretaker or attorney, you need to leave the  
09:24:45 10 courtroom and then come back when you are called.

09:24:49 11 Counsel, I just need to ask for  
09:24:51 12 your help, because I don't know who all of the fact  
09:24:54 13 witnesses are. If you see someone in the courtroom  
09:24:56 14 who is a fact witness, let me know and I will ask  
09:25:00 15 them to leave.

09:25:01 16 MR. COREY SMITH: Very well, Your  
09:25:03 17 Honor.

09:25:04 18 THE COURT: Then the final issue on  
09:25:05 19 your list was subpoenas?

09:25:07 20 MR. COREY SMITH: Well, there's one  
09:25:08 21 particular witness, Dr. Maria Ponisio. She was a  
09:25:11 22 witness -- an expert that we retained. She's a  
09:25:14 23 radiologist, nuclear radiologist. She's never met  
09:25:19 24 Mr. Brockman. She was just retained by the  
09:25:21 25 Government to review some of the imaging and she

09:25:23 1 wrote a report, which the Defense has.

09:25:25 2 We were initially going to call  
09:25:27 3 her, but in speaking to Dr. Ponisio, she's up in  
09:25:30 4 St. Louis and she works at the George Washington  
09:25:33 5 Hospital up there, and she has a lot -- her -- there  
09:25:36 6 was a scheduling conflict. So we believe that her  
09:25:39 7 testimony is going to be -- very much duplicative of  
09:25:42 8 our very first witness, our neurologist, Dr. Darby  
09:25:46 9 so we decided not to call her and waste everyone's  
09:25:50 10 time to call her to hear the same thing again.  
09:25:52 11 Since that time Defense has subpoenaed her to  
09:25:54 12 testify.

09:25:54 13 She's concerned that she may not be  
09:25:58 14 able to come down in the appropriate time to  
09:26:00 15 testify. She has to be back -- again, not to take  
09:26:04 16 up the Court's time with these minutiae, but she has  
09:26:07 17 clinic duties at the children's hospital on Saturday  
09:26:10 18 morning, so she has to be out of here Friday night.  
09:26:12 19 She has agreed to testify via video if the Defense  
09:26:15 20 really wants to call her.

09:26:17 21 So we would ask if they do really  
09:26:19 22 want to call Dr. Ponisio to let her testify via  
09:26:22 23 video conferencing.

09:26:23 24 THE COURT: Okay. Was she in the  
09:26:26 25 jurisdiction of the Court at the time she was

09:26:28 1 served, or how did this happen?

09:26:30 2 MR. COREY SMITH: I'll let Mr. Loomas  
09:26:31 3 [SIC] address that.

09:26:32 4 MR. LOONAM: Your Honor, a little  
09:26:33 5 background --

09:26:37 6 MR. COREY SMITH: I'm sorry, I got your  
09:26:39 7 name wrong.

09:26:41 8 MR. LOONAM: Dr. Ponisio is the  
09:26:43 9 Government's retained neuroradiologist who has  
09:26:47 10 reviewed the imaging in this case. She's issued  
09:26:50 11 four reports, some reviewing one scan, some  
09:26:55 12 combining scans. Um, and each of those reports has  
09:26:59 13 -- well, the last report said that -- that the most  
09:27:03 14 likely diagnosis to come out of the reports was  
09:27:10 15 early Alzheimer's in the correct clinical situation.

09:27:14 16 Um, and that -- that the, um,  
09:27:17 17 imaging most strongly supported early Alzheimer's.  
09:27:20 18 That's -- that's different than what Dr. Denney will  
09:27:26 19 testify to, the Government's main witness in this  
09:27:29 20 case. So it's just an incredibly important witness.

09:27:31 21 Um, Dr. Ponisio was not on the  
09:27:34 22 Government's witness list. Um, we informed the  
09:27:37 23 Government on November 8th that we were adding  
09:27:41 24 Dr. Ponisio to our witness list, and asked if the  
09:27:44 25 Government would make her available. Um, Mr. Smith

09:27:47 1 responded that Dr. Ponisio had a conflict for the  
09:27:53 2 week of November 15th -- the entire week of  
09:27:57 3 November 15th.

09:27:57 4 "She's based in St. Louis, but is  
09:28:00 5 able to testify via video conferencing, and would  
09:28:02 6 you like us to forward you contact information?"

09:28:06 7 We said yes, and Mr. Smith  
09:28:07 8 forwarded her contact information. I spoke with  
09:28:11 9 Dr. Ponisio on Friday with, um, my colleague, Conor  
09:28:17 10 Maloney on the phone with me. Dr. Ponisio actually  
09:28:21 11 had -- she said some things that are a little  
09:28:23 12 different than what the Government just said. She  
09:28:25 13 said she was told by the Government she would never  
09:28:28 14 have to testify when she was retained, and never  
09:28:31 15 have to testify.

09:28:32 16 I told her, "Well, I'm sorry to be  
09:28:34 17 the bearer of bad news, but you might have to  
09:28:37 18 testify. I don't know, and I want to be respectful  
09:28:39 19 of your schedule. I want to be respectful of your  
09:28:43 20 conflicts, so what is your conflict for this week,  
09:28:45 21 what conflict do you have?"

09:28:46 22 She's, like, "Well" -- and there's  
09:28:48 23 no conflict other than what every doctor in this  
09:28:52 24 case is dealing with. Maybe, "I have this," or "I'm  
09:28:55 25 preparing for a presentation on this day."

09:28:57 1 And very quickly when I said,  
09:28:59 2 "Well, you know, this is a really important matter,"  
09:29:01 3 she said, "It's better to know sooner rather than  
09:29:05 4 later if I need to travel."

09:29:06 5 "I don't want to needlessly  
09:29:09 6 inconvenience you."

09:29:10 7 So depending on how the  
09:29:12 8 Government's witness, Dr. Darby, who they plan on  
09:29:14 9 having testify about Dr. Ponisio's expert report,  
09:29:18 10 Dr. Darby, who will be the first witness, is a  
09:29:20 11 neurologist. He's not a neuroradiologist. I don't  
09:29:24 12 know if his opinion is going to be consistent or  
09:29:26 13 different from what Dr. Ponisio -- Dr. Ponisio's  
09:29:30 14 reports say.

09:29:31 15 And so, what I told Dr. Ponisio is  
09:29:35 16 let me hear from the witnesses on Monday, um, and  
09:29:37 17 then we will talk, and hopefully I'm better informed  
09:29:41 18 as to whether we need you to testify or not. And  
09:29:43 19 then we'll let you know as soon as we can.

09:29:45 20 So we're -- and that's the plan for  
09:29:48 21 us to call Dr. Ponisio tonight, um, to let her know  
09:29:51 22 if we indeed need to call her and she needs to  
09:29:55 23 travel, and we'll work with her schedule just like  
09:29:56 24 we have for every other witness in this case.

09:29:58 25 THE COURT: Okay.

09:29:59 1 Response, Mr. Smith?

09:30:01 2 MR. COREY SMITH: That sounds  
09:30:03 3 reasonable, Judge. If we can address this after  
09:30:05 4 Dr. Darby testifies, and if they don't have an issue  
09:30:10 5 with Dr. Darby's testimony we can -- well, we don't  
09:30:13 6 know what Dr. Darby is going to say, but after he  
09:30:16 7 testifies we can readdress this issue. Sounds like  
09:30:18 8 a reasonable solution.

09:30:19 9 THE COURT: Okay.

09:30:22 10 MR. LOONAM: Sorry, Dr. Darby is the  
09:30:24 11 main witness. I think if Dr. Denney's testifying  
09:30:28 12 today, too, we'll want to see what Dr. Denney says  
09:30:31 13 about the scans if he's going to testify with  
09:30:33 14 respect to the scans. I don't know, but by the end  
09:30:36 15 of the day.

09:30:36 16 We plan on calling -- I think we --  
09:30:39 17 I said a time around six o'clock to speak with  
09:30:43 18 Dr. Ponisio.

09:30:43 19 THE COURT: Okay. Great. Mr. Varnado?

09:30:48 20 MR. VARNADO: On this topic of experts  
09:30:50 21 and timing, I did want to note for the Court, and  
09:30:52 22 we'll confer with the Government as well, that we do  
09:30:54 23 have one expert, Dr. Wisniewski that absolutely has  
09:30:59 24 to have a full clinic day on Thursday. You know, we  
09:31:01 25 had mentioned in a prior hearing we may need to call

09:31:04 1 some doctors out of order.

09:31:05 2 He is one that we would want to put  
09:31:07 3 on the Wednesday lunch break. Maybe the  
09:31:09 4 Government's done by that time -- entirely possible,  
09:31:12 5 but I want to flag for the Court this is somebody  
09:31:14 6 who is coming in very, very late Tuesday. Has to  
09:31:17 7 absolutely leave late -- you know, will get the  
09:31:20 8 latest flight out. But wanted to flag that we may  
09:31:23 9 need Dr. Wisniewski out of order after the lunch  
09:31:26 10 break on Wednesday.

09:31:27 11 THE COURT: Definitely, Mr. Varnado.  
09:31:31 12 I'm going to accommodate the doctors' schedules to  
09:31:35 13 the best of the Court's ability. They're taking  
09:31:37 14 care of people that have lives at stake. Whatever  
09:31:41 15 we need to do to accommodate them we're doing.

09:31:45 16 MR. COREY SMITH: Absolutely fine for  
09:31:47 17 the Government, Your Honor.

09:31:47 18 THE COURT: Great.

09:31:48 19 MR. VARNADO: One issue I added, Judge?

09:31:50 20 THE COURT: Sure.

09:31:51 21 MR. VARNADO: We got some  
09:31:53 22 demonstratives from the Government last night about  
09:31:55 23 5:30 --

09:31:56 24 MR. LOONAM: 6:00 --

09:31:58 25 MR. VARNADO: Yeah, six o'clock

09:32:00 1 pertaining to Dr. Darby and Dr. Denney. I'll let  
09:32:03 2 Mr. Loonam address the specifics, but to tee it up  
09:32:06 3 these demonstratives contain information and  
09:32:10 4 references to source material, including academic  
09:32:12 5 studies that were never referenced in their prior  
09:32:17 6 expert reports. Each of these experts had two  
09:32:19 7 reports, Dr. Denney and Dr. Darby, and they did not  
09:32:23 8 refer to this material.

09:32:24 9 So I'll let Mr. Loonam expand  
09:32:26 10 further, but it's our position that, you know, this  
09:32:29 11 is new information and we object to it being  
09:32:32 12 included at this very late hour. We don't have  
09:32:34 13 time, you know, to run it past our experts and dig  
09:32:36 14 in. It's highly technical academic studies on these  
09:32:40 15 topics.

09:32:41 16 MR. LOONAM: I don't want to take up  
09:32:43 17 the Court's time, Judge. The only thing I'd add is  
09:32:46 18 we received two sets of demonstratives last night.  
09:32:49 19 One was for Dr. Denney, which we're not objecting  
09:32:51 20 to. It's the Dr. Darby slides -- the expert reports  
09:32:55 21 were due October 29th in this case. DOJ missed that  
09:33:00 22 deadline by a day.

09:33:01 23 Then on November 1st, we appeared  
09:33:03 24 before the Court because one of the expert reports  
09:33:06 25 seemed to leave wiggle room for changing the

09:33:08 1 opinion. We said, "Wait, we need notice to prepare  
09:33:13 2 this case."

09:33:13 3 It's a highly technical case. Lot  
09:33:16 4 of experts. We're talking about the brain and  
09:33:18 5 neurology. It's tough, technical stuff. And so,  
09:33:22 6 the Court stated, "Absolutely, you need" -- and gave  
09:33:27 7 the Government the opportunity to supplement -- by  
09:33:31 8 the way the Government said it wasn't going to  
09:33:35 9 supplement, and then did after it represented it  
09:33:38 10 wasn't going to.

09:33:39 11 But then Your Honor said, you know,  
09:33:40 12 "By Monday, November 8th the Government needs to  
09:33:44 13 provide all supplemental reports or show good cause  
09:33:47 14 why not."

09:33:48 15 So that's where we are. And then,  
09:33:51 16 last night -- I don't know 5:00 or 6:00, because my  
09:33:54 17 clock is off because of New York time frankly, and I  
09:33:57 18 don't know if my computer switched back. So we'll  
09:33:59 19 call it five o'clock on Sunday night we got an  
09:34:02 20 e-mail of what they say are demonstratives, but  
09:34:05 21 really this is a supplement to the expert report.

09:34:08 22 The first page includes, "Dementia  
09:34:12 23 progression with beta-amyloid tau neuronal imagery  
09:34:17 24 dysfunction brain structure," with a site to  
09:34:19 25 *Alzheimer's Research and Therapy Vol. II* (phonetic).

09:34:23 1 This is a book they're relying on. We're entitled  
09:34:26 2 to the opinion of the expert, and the bases for the  
09:34:28 3 opinion. This raises a new basis of their opinion  
09:34:30 4 right here.

09:34:31 5 Then if you go through this, Judge,  
09:34:32 6 some of this is, like, summary slides more for  
09:34:36 7 closing. But, you know, that's not what I'm raising  
09:34:39 8 the main objection to. Here's a slide with the  
09:34:43 9 brain images, but then two articles cited at the  
09:34:45 10 bottom, right?

09:34:47 11 One article here says, "Posterior  
09:34:50 12 paroccipital hypometabolism may differentiate" --  
09:35:03 13 "posterior paraoccipital hypometabolism may  
09:35:09 14 differentiate mild cognitive impairment from  
09:35:12 15 dementia in Parkinson's disease."

09:35:14 16 That's just an example, Judge.  
09:35:16 17 It's very important issue in this case, and it's --  
09:35:19 18 it's a new basis for Dr. Darby's opinion.  
09:35:23 19 Dr. Darby's report has been out for quite some time.  
09:35:26 20 Our reports cited medical literature so that their  
09:35:29 21 experts could review the medical literature, see if  
09:35:32 22 there was something for them so they could prepare  
09:35:34 23 for cross.

09:35:35 24 I got this five o'clock last night,  
09:35:38 25 middle of preparing on a Sunday. It's -- there's

09:35:41 1 another article here. These are very technical,  
09:35:44 2 dense medical literature and research. I should  
09:35:49 3 have the opportunity to read this, see if there's  
09:35:52 4 conflicting medical research out there, consult with  
09:35:56 5 my expert in order to properly cross their expert.

09:36:00 6 I can't do that, um, because of --  
09:36:03 7 and these slides weren't prepared last night and  
09:36:06 8 thrown together. There's been work put in these,  
09:36:09 9 Your Honor. To receive this five o'clock before  
09:36:11 10 appearing before Your Honor tonight is just  
09:36:13 11 inappropriate, so we object. We object to it.

09:36:16 12 We are prepared to go, but they  
09:36:19 13 shouldn't be able to use this.

09:36:20 14 THE COURT: Okay.

09:36:21 15 Response?

09:36:23 16 MR. MAGNANI: Your Honor, Christopher  
09:36:25 17 Magnani for the United States. I definitely agree  
09:36:28 18 with my colleague this is tough, technical stuff. I  
09:36:31 19 understand why they would object, because it  
09:36:33 20 clarifies the tough technical stuff and puts it in a  
09:36:36 21 way that's easy for lay people to understand. So  
09:36:39 22 kind of like with sequestration, Your Honor, the  
09:36:41 23 goal here is to help the Court as fact finder get  
09:36:44 24 through this tough technical stuff.

09:36:46 25 THE COURT: I'm with you, with the

09:36:48 1 charts, but the references to articles or books or  
09:36:54 2 treatises that weren't disclosed as part of the  
09:36:57 3 expert opinion.

09:36:58 4 MR. MAGNANI: Basically, Your Honor,  
09:36:59 5 the way I describe that is they're not necessary for  
09:37:01 6 the demonstratives. We put them as sort of  
09:37:04 7 footnotes. If Defense expert is wondering, "Where  
09:37:07 8 did this come from," it gives them the ability to do  
09:37:09 9 that.

09:37:10 10 That way if their experts want to  
09:37:11 11 dig in to that, testify in their case when they put  
09:37:14 12 in the opposite number -- so in other words our  
09:37:16 13 first witness is a neurologist. They call their  
09:37:19 14 neurologist, and they'll have the benefit of the  
09:37:20 15 pictures and footnotes that ours used as a  
09:37:24 16 demonstrative and say, "This is why they're unfair,  
09:37:26 17 this is why they're wrong."

09:37:27 18 This was prepared a long time ago,  
09:37:30 19 I have no idea what Counsel's basis for saying that  
09:37:33 20 was. If you want to ask Dr. Darby when he's under  
09:37:36 21 oath, we were working on these slides last night and  
09:37:39 22 we sent them the second they were done.

09:37:42 23 THE COURT: Before you continue, couple  
09:37:43 24 of questions. First, the slides with respect to the  
09:37:46 25 charts, are those charts based on information that

09:37:51 1 was disclosed in discovery or treatises or journals  
09:37:55 2 that were disclosed in discovery?

09:37:58 3 MR. MAGNANI: It's a very good  
09:37:59 4 question, Your Honor. All of the information that  
09:38:01 5 it's portraying is all in discovery. The only new  
09:38:04 6 thing is pictures -- you know, either a  
09:38:06 7 demonstrative chart that shows -- that demonstrates  
09:38:09 8 complex concepts, as opposing counsel said summaries  
09:38:13 9 of different experts' opinions that just helps put  
09:38:16 10 everything in perspective, and some pictures that  
09:38:19 11 are published in, um, you know brain science  
09:38:23 12 literature that basically says this is a combination  
09:38:27 13 -- this is what a typical brain image looks like in  
09:38:30 14 these cases.

09:38:31 15 So the last one is the one that  
09:38:33 16 comes from the literature. Basically what we're  
09:38:35 17 trying to do is say are these scans that we're  
09:38:38 18 looking at in this case -- do we have to look at  
09:38:40 19 them in isolation or compare them to the body of  
09:38:43 20 science that exists? So that comparison is very  
09:38:45 21 helpful to the fact finder to see.

09:38:49 22 Again, the study is cited, and so  
09:38:50 23 if there's a problem their experts can talk about it  
09:38:52 24 in their case. Frankly, if they want to  
09:38:55 25 cross-examine Dr. Darby, and they don't feel

09:38:58 1 prepared today, he can be recalled for that purpose.

09:39:00 2 THE COURT: I guess what my problem and  
09:39:02 3 my concern is what Mr. Loonam points out is the  
09:39:05 4 articles themselves, or the journals that are being  
09:39:08 5 used aren't something that were disclosed to  
09:39:12 6 Mr. Loonam or his client timely.

09:39:14 7 I mean, do we need the footnotes?  
09:39:19 8 Can you take the footnotes out and the  
09:39:20 9 demonstratives remain the same?

09:39:23 10 MR. MAGNANI: One hundred percent, Your  
09:39:24 11 Honor. The footnotes are there only for the Defense  
09:39:27 12 and their experts to evaluate whether we chose  
09:39:30 13 unfair examples or things since refuted. But in  
09:39:33 14 terms of what's going to help someone who is not a  
09:39:36 15 neurologist understand this stuff, you just need to  
09:39:39 16 see the pictures of the footnotes are not important.

09:39:41 17 THE COURT: Okay.

09:39:42 18 MR. LOONAM: If I heard Mr. Magnani  
09:39:45 19 correctly, the footnotes are there because it's  
09:39:47 20 citation to new pictures that could very well be  
09:39:51 21 helpful to the Court. I don't know. That's not  
09:39:53 22 sort of the standard here. The pictures are new,  
09:39:56 23 not disclosed.

09:39:57 24 Pulled them -- I guess last night a  
09:39:59 25 treatise they thought would be helpful and put them

09:40:01 1 on a slide and they're -- this is a supplemental  
09:40:04 2 expert report. I haven't heard good cause, which  
09:40:06 3 was the standard for -- for any supplemental expert  
09:40:09 4 report. And to -- to go through direct where I  
09:40:12 5 can't properly cross and the -- and the -- and the  
09:40:14 6 answer is, um, "Well, have your experts review, and  
09:40:17 7 they can then testify about it because we're giving  
09:40:20 8 you the basis for the opinion now," that -- in and  
09:40:23 9 of itself -- makes very clear this is a supplemental  
09:40:26 10 expert report produced to us 5:00 p.m. on Sunday  
09:40:28 11 night before we appeared here after the Court  
09:40:31 12 admonished the Government to -- to supplement any  
09:40:35 13 expert reports by the 8th.

09:40:36 14 THE COURT: Okay. What I'm trying to  
09:40:37 15 figure out is the supplemental report -- is it  
09:40:40 16 changing the opinion in any way, or is it -- or is  
09:40:42 17 it a different opinion? It sounds like -- I'm  
09:40:45 18 sorry, I didn't mean to interrupt, but it sounds  
09:40:47 19 like what you are doing -- I want to be clear on, is  
09:40:50 20 that you are providing graphs and charts that  
09:40:53 21 further explain the position that you are going to  
09:40:55 22 be testifying about?

09:40:56 23 MR. MAGNANI: Your Honor, that's right.  
09:40:57 24 And I think -- you can understand why counsel wants  
09:41:00 25 to describe it as a supplemental expert report,

09:41:02 1 because that would require cause. But as I said  
09:41:04 2 from the beginning, and as opposing counsel said  
09:41:07 3 from the beginning, it's a demonstrative exhibit.  
09:41:09 4 So it does not change the opinions in the expert  
09:41:12 5 reports that were filed, it just does what a  
09:41:14 6 demonstrative exhibit does.

09:41:15 7 It demonstrates those opinions to a  
09:41:17 8 lay person who does not have as much experience  
09:41:20 9 understanding the type of technical stuff we're  
09:41:22 10 talking about.

09:41:23 11 THE COURT: Is this in opening or part  
09:41:25 12 of the direct?

09:41:26 13 MR. MAGNANI: Only as part of  
09:41:29 14 Dr. Darby's direct. Frankly, Your Honor, if it  
09:41:30 15 would aid the Court in helping to sort this out, I  
09:41:33 16 have printed copies of it.

09:41:35 17 THE COURT: Can I take a look at it?  
09:41:37 18 Give me about five minutes, and I'm going to take a  
09:41:39 19 look and just take a quick recess.

09:41:42 20 MR. LOONAM: Judge, to be clear,  
09:41:43 21 pictures are new.

09:41:44 22 THE COURT: Yeah, you are saying you  
09:41:45 23 have never seen this before. I want to take a look  
09:41:47 24 and I'll be right back.

09:41:59 25 (Whereupon, off the record.)

09:41:59 1 THE COURT: Is Dr. Yudofsky's counsel  
09:42:01 2 here also? Okay because I understood -- that was  
09:42:06 3 one of the things I wanted to take up with the  
09:42:08 4 parties. He asked -- he filed a motion asking to be  
09:42:11 5 able to address the Court. I didn't have any --  
09:42:13 6 nobody objected. I don't see why there isn't -- a  
09:42:16 7 reason to keep him from addressing the Court if he  
09:42:18 8 wanted to -- or she. I'm not sure.

09:42:21 9 MR. VARNADO: It's Mr. MacDougall, I  
09:42:23 10 believe.

09:42:26 11 MR. LANGSTON: Your Honor, we don't  
09:42:26 12 have an objection to the attorney being heard.  
09:42:29 13 Mr. MacDougall had requested, sort of, what day we  
09:42:30 14 anticipated calling Dr. Yudofsky, and we told him it  
09:42:33 15 was going to be Wednesday. But if the Court would  
09:42:36 16 want, I can tell Mr. MacDougall -- if you want to  
09:42:39 17 speak to him we can have him here tomorrow.

09:42:41 18 THE COURT: No, it's not a problem. I  
09:42:43 19 just wanted to grant his motion to appear before the  
09:42:46 20 Court if he was waiting. Let's take five minutes.  
09:42:49 21 (Off the record.)

09:51:24 22 Okay. Counsel, we're back on the  
09:51:26 23 record. I just have a few questions before we get  
09:51:28 24 started.

09:51:29 25 First, I'm looking at what you

09:51:30 1 handed me, which was Dr. Darby's demonstrative  
09:51:35 2 exhibits -- or demonstrative slides. Page 1,  
09:51:41 3 "Dementia Progression," is this a chart created by  
09:51:43 4 the expert, or something that came out of  
09:51:45 5 *Alzheimer's Research & Therapy Volumes II, 23 2010?*

09:51:51 6 MR. MAGNANI: My understanding is that  
09:51:52 7 it came from that, but I would have to double check  
09:51:55 8 with Dr. Darby who is in the courtroom, Your Honor.

09:51:57 9 THE COURT: Please double check.  
09:51:58 10 Because if -- if it's not something he created and  
09:52:01 11 it came from this book, I'm not going to allow it.  
09:52:03 12 I think Mr. Loonam is absolutely correct. The  
09:52:09 13 problem is if these cites weren't necessary to show  
09:52:14 14 where these documents came from, then they wouldn't  
09:52:18 15 be there.

09:52:21 16 Since they're there, that means  
09:52:24 17 they're pulled from some secondary source.

09:52:26 18 Mr. Loonam, if you're telling me  
09:52:29 19 you haven't seen the secondary sources and your  
09:52:31 20 experts haven't, then it's not coming in.

09:52:33 21 MR. MAGNANI: Your Honor, the only  
09:52:34 22 thing I would point out -- again, you could ask this  
09:52:36 23 of Dr. Darby, but I think he would testify these  
09:52:41 24 slides are fair and accurate depictions of certain  
09:52:44 25 things.

09:52:44 1 On that basis -- in other words, I  
09:52:46 2 believe he could lay the foundation to admit these  
09:52:48 3 as actual exhibits, which we're not trying to do.  
09:52:51 4 We're not trying to say they're evidence, but I'll  
09:52:53 5 put that out there.

09:52:54 6 THE COURT: The problem is they weren't  
09:52:55 7 disclosed to the other side. It doesn't matter.  
09:52:58 8 I'm not disputing the fact it could be evidence. It  
09:53:02 9 could be, but what Mr. Loonam's point is that it  
09:53:05 10 wasn't disclosed to him timely in preparation for  
09:53:09 11 this hearing, which places him at the disadvantage  
09:53:11 12 of preparing his case for his client.

09:53:13 13 I think I'm summarizing that.

09:53:16 14 MR. LOONAM: Absolutely right. Whether  
09:53:17 15 it's accurate or not, I don't know. Whether there's  
09:53:19 16 other evidence out there, I don't know. So you are  
09:53:21 17 right, Your Honor, 100 percent.

09:53:24 18 THE COURT: So unless Dr. Darby is  
09:53:27 19 going to testify this is a chart he created and it's  
09:53:29 20 not pulled from the reference materials, then I  
09:53:34 21 won't allow it as demonstrative evidence in this  
09:53:36 22 case. Same with -- at least on page numbers, but  
09:53:41 23 the -- it looks like scans of a brain that cite to  
09:53:47 24 "Garcia", and "Garcia and Edison".

09:53:51 25 If those aren't slides that

09:53:54 1 Dr. Darby created, and these are pulled from those  
09:53:58 2 two reference materials, I'm not going to allow  
09:54:01 3 those either.

09:54:01 4 So as I said, Mr. Loonam, I think  
09:54:05 5 you are absolutely correct -- Loonam, I'm sorry.  
09:54:09 6 You are absolutely correct.

09:54:17 7 Then there's another one from  
09:54:18 8 "Garcia" and "Garcia and Edison" as well, but it's  
09:54:22 9 later on in the slide presentation. If those aren't  
09:54:27 10 slides that were created by Dr. Darby, and they're  
09:54:31 11 slides that were pulled from those reference  
09:54:33 12 materials, then I'm not going to allow those either.

09:54:40 13 Do you need to ask Dr. Darby those  
09:54:42 14 questions?

09:54:42 15 MR. MAGNANI: I would like to double  
09:54:43 16 check, Your Honor, and I would also like to double  
09:54:45 17 check -- I know Your Honor didn't mention it, but  
09:54:47 18 consistent with that ruling I might also need to  
09:54:49 19 check with him about the -- there's a slide after  
09:54:53 20 the first brain scans. There's no footnote, but I'm  
09:54:57 21 just not sure. It's the one with the.

09:55:03 22 MR. LOONAM: That comes --

09:55:04 23 THE COURT: Looks like "Brockman MRI"

09:55:06 24 --

09:55:07 25 MR. LOONAM: That comes from the

09:55:08 1 Neuroreader® (phonetic). That's been disclosed.

09:55:12 2 THE COURT: Okay.

09:55:15 3 MR. MAGNANI: Your Honor, do you mind  
09:55:16 4 if I take a minute? I do -- I would like to double  
09:55:19 5 check.

09:55:19 6 THE COURT: Sure. Not a problem.

09:55:55 7 MR. MAGNANI: Apologies, your Honor. I  
09:55:57 8 didn't steer you wrong. Dr. Darby confirmed  
09:56:00 9 everything I said was correct. The only caveat is  
09:56:02 10 that the slides with the brain scans -- and if Your  
09:56:09 11 Honor is looking at them, there are the orange ones  
09:56:11 12 and the blue ones. And I think this is clear, but I  
09:56:14 13 want to make it abundantly clear, it's the first  
09:56:17 14 two. The orange ones and the other ones from like,  
09:56:20 15 you know, Mr. Brockman's brain scans and were of  
09:56:23 16 course, you know, disclosed in this case.

09:56:25 17 THE COURT: Okay. If you want to  
09:56:27 18 redact the information that was taken from the --  
09:56:34 19 from the treatises, that's fine, and leave  
09:56:38 20 Mr. Brockman's scan that was disclosed, that's  
09:56:41 21 great.

09:56:41 22 But the ones that were taken from  
09:56:43 23 the treatises I'm not allowing, so they need to be  
09:56:47 24 removed.

09:56:47 25 MR. MAGNANI: One qualifying question,

09:56:50 1 Your Honor, is that also if Dr. Darby were to  
09:56:52 2 testify the orange scans, which he did pull from the  
09:56:55 3 literature, are approximations of what he would  
09:56:57 4 expect to see and what he does see in his clinical  
09:57:00 5 practice?

09:57:01 6 THE COURT: He can just testify to  
09:57:02 7 that.

09:57:02 8 MR. MAGNANI: Okay.

09:57:02 9 THE COURT: The problem is if these  
09:57:04 10 scans are from this -- these reference materials and  
09:57:08 11 Mr. Loonam was saying, "I've not seen them," and  
09:57:11 12 nobody disputes that, then they're not in.

09:57:15 13 MR. MAGNANI: Very well, Your Honor.

09:57:16 14 THE COURT: Okay. So during opening I  
09:57:21 15 guess -- or I guess during opening you will have an  
09:57:24 16 opportunity to modify your demonstratives as  
09:57:27 17 necessary. I assume somebody else will be doing  
09:57:30 18 opening?

09:57:32 19 MR. MAGNANI: Fortunately for me that's  
09:57:34 20 true, Your Honor.

09:57:34 21 THE COURT: Okay. Great. That was  
09:57:49 22 issues you raised and the issues I had.

09:57:52 23 Anything else before we get  
09:57:53 24 started?

09:57:55 25 MR. LOONAM: I think that's it, Your

09:57:56 1 Honor.

09:57:57 2 MR. COREY SMITH: I think that's it,  
09:57:58 3 Your Honor.

09:57:58 4 THE COURT: Okay. Great. We'll  
09:57:59 5 proceed with opening statements. As I said, I need  
09:58:02 6 a statement, not argument. Provide me a roadmap.  
09:58:08 7 Preliminary briefings are excellent, Counsel. Great  
09:58:11 8 job sending it out for me, connecting all of the  
09:58:13 9 dots. Before now, I've only seen bits and pieces.  
09:58:17 10 It was very, very well done.

09:58:18 11 So if you can follow up with a good  
09:58:20 12 opening, give me a roadmap of where you are going,  
09:58:22 13 and then we'll get started.

09:58:25 14 Government, you may proceed when  
09:58:27 15 ready.

09:58:29 16 MR. LANGSTON: Thank you. Lee Langston  
09:58:38 17 for the Government. Your Honor, what you are going  
09:58:41 18 to see over the next few days is the extraordinary  
09:58:43 19 lengths a man is willing to go to evade  
09:58:46 20 accountability of the largest tax fraud in US  
09:58:49 21 history. The evidence will clearly show the  
09:58:53 22 Defendant has been living a double life for years.

09:58:54 23 He's been lying to doctors,  
09:58:57 24 exaggerating his symptoms in a desperate attempt to  
09:59:00 25 evade prosecution in this case.

09:59:02 1 He didn't see a doctor about his  
09:59:05 2 mental capacity until after the key search warrant  
09:59:07 3 in this case, and he didn't resign from his position  
09:59:11 4 as CEO of his company until after his indictment was  
09:59:14 5 unsealed.

09:59:16 6 The evidence will show that the  
09:59:18 7 Defendant had the motivation to malingering, that he  
09:59:21 8 has the capacity to successfully deceive trained  
09:59:24 9 doctors, and that he is presently exaggerating and  
09:59:29 10 malingering his symptoms.

09:59:31 11 The first part of our case will be  
09:59:32 12 discussing the motivation for the Defendant to  
09:59:34 13 malingering. Our doctors will tell you that's  
09:59:37 14 important, because understanding the strength of the  
09:59:39 15 evidence against him and the seriousness of the  
09:59:41 16 charges helps you understand the Defendant's  
09:59:43 17 motivation to fabricate a serious illness.

09:59:48 18 For more than 30 years the  
09:59:50 19 Defendant was engaged in a complex scheme to hide  
09:59:52 20 the vast majority -- billions of dollars of assets  
09:59:55 21 in offshore trusts. You are going to hear that for  
09:59:59 22 30 years he successfully deceived the Government,  
10:00:02 23 banks, and those close to him about his true  
10:00:05 24 financial condition.

10:00:06 25 You'll see that he used his same

1 formidable powers of organization and intellect that  
2 he used to build his business to hide that from the  
3 IRS. The largest and most important part of this is  
4 The A. Eugene Brockman Charitable Trust, and I think  
5 you will hear people refer to it as The Brockman  
6 Trust. It controlled more than \$10 billion in  
7 assets, including the Defendant's software company,  
8 Reynolds and Reynolds.

9 He controlled this offshore empire  
10 through a series of nominees. In 2018, the most  
11 important of those nominees was a man named Evatt  
12 Tamine. You are going to hear from Mr. Tamine  
13 either today or this week. You'll hear that on  
14 paper, his role was to be the independent trustee of  
15 The Brockman Trust.

16 He's going to testify to you that  
17 in reality, however, he was paid millions of dollars  
18 a year from the Defendant to hide the Defendant's  
19 control and absolute direction over these  
20 structures. He's going to tell you that Mr. Tamine  
21 and Mr. Brockman communicated using a bespoke,  
22 encrypted messaging service.

23 And that because of their  
24 confidence in this encryption, the Defendant and  
25 Mr. Tamine conspired openly -- that they talked in

10:01:21 1 very clear language about hiding the Defendant's  
10:01:25 2 control over the structure from the world. They  
10:01:28 3 spoke so openly on the server that Mr. Tamine  
10:01:32 4 boasted to the Defendant in writing, in a formal  
10:01:36 5 performance review, he had done such a good job  
10:01:40 6 destroying evidence in this case, an attempt to  
10:01:42 7 search a close associate's house would be fruitless.

10:01:44 8 Now, in contrast to the way they  
10:01:47 9 spoke in this encrypted messaging system, you will  
10:01:49 10 also hear about something the Defendant refers to as  
10:01:52 11 something called open correspondence. This is  
10:01:54 12 letters or e-mails designed to be seen. And rather  
10:01:58 13 than send these through the encrypted system, they  
10:02:01 14 would send these in the open. The reason for that  
10:02:03 15 is to create a false paper trail that could one day  
10:02:06 16 be pointed to support the Defendant's cover story.

10:02:10 17 You'll see that the Defendant was a  
10:02:12 18 man careful enough to create a fake document today  
10:02:16 19 that could get him out of hot water years into the  
10:02:20 20 future. You are also going to hear about how this  
10:02:23 21 didn't quite work. That beginning in 2016, despite  
10:02:27 22 their careful planning, the Defendant and Mr. Tamine  
10:02:30 23 began to feel the walls closing in.

10:02:32 24 In 2016, the Defendant learned of a  
10:02:35 25 US investigation into Robert Smith, the founder of

10:02:38 1 Vista Equity Partners.

10:02:40 2                   The relationship between Vista and  
10:02:43 3 the Defendant is important, because they were  
10:02:44 4 concerned that an investigation into Vista could  
10:02:47 5 turn into investigation into them. You'll hear that  
10:02:52 6 the Defendant played a large role in creating Vista.  
10:02:55 7 The Brockman Trust was the sole investor in the  
10:02:59 8 first Vista private equity fund. At the creation of  
10:03:02 9 that -- at the creation of the Vista equity fund,  
10:03:04 10 the founder, Mr. Smith -- he also created an  
10:03:07 11 offshore trust to hide income from the IRS.

10:03:10 12                   Mr. Smith used the same lawyer,  
10:03:13 13 Carlos Kepke, as had created The Brockman Trust.  
10:03:17 14 Mr. Kepke is the architect of the Brockman offshore  
10:03:21 15 structure. And the Defendant again worried an  
10:03:24 16 investigation into Mr. Smith or Mr. Kepke could turn  
10:03:28 17 into investigation into The Brockman Trust.

10:03:30 18                   That turned out to be a prescient  
10:03:32 19 worry. September of 2016, Vista receives a subpoena  
10:03:35 20 from the US Government. As part of that subpoena,  
10:03:38 21 it requests records of Vista's investors, including  
10:03:41 22 The Brockman Trust. Defendant had Mr. Tamine meet  
10:03:45 23 with Mr. Smith -- meet with Mr. Smith's lawyers, and  
10:03:49 24 ordered Mr. Tamine to destroy evidence in the US in  
10:03:52 25 an attempt to contain the damage. You'll hear he

10:03:56 1 flew sometimes halfway around the world, making  
10:03:59 2 trips over and over again to the US to destroy  
10:04:01 3 documents.

10:04:02 4 In 2017, they learned that several  
10:04:05 5 bank accounts associated with The Brockman Trust had  
10:04:07 6 been frozen in Bermuda. You'll see a memo  
10:04:11 7 Mr. Tamine wrote Mr. Brockman about that freezer --  
10:04:14 8 about that freeze, saying they needed to muddy the  
10:04:17 9 waters about Mr. Tamine's physical location. They  
10:04:20 10 needed an escape jurisdiction.

10:04:22 11 Mr. Tamine could never again travel  
10:04:24 12 to the US, and he -- even if he could, he could  
10:04:28 13 never do it with a phone or computer. Mr. Brockman  
10:04:31 14 wrote back to Mr. Tamine saying he agreed with every  
10:04:34 15 concern Mr. Tamine raised in that memo.

10:04:38 16 Things got more serious in 2018.  
10:04:40 17 In August of 2018, there was a search warrant of  
10:04:43 18 Mr. Kepke's law office. Mr. Kepke called  
10:04:45 19 Mr. Tamine, and he tells him that Mr. Tamine and the  
10:04:48 20 Defendant's names are both listed in the warrant.  
10:04:52 21 As soon as he hangs up with Mr. Kepke, Mr. Tamine  
10:04:55 22 calls Mr. Brockman and relays that information to  
10:04:57 23 him. He will testify that after the Kepke warrant,  
10:05:00 24 he was as rattled as he had ever seen Mr. Brockman  
10:05:03 25 in 14 years of working for him.

1 Then, on September 5th, Bermuda  
2 authorities execute a search at Mr. Tamine's home.  
3 The significance of that is among the items seized  
4 is a hard drive containing comprehensive records of  
5 The Brockman Trust, and their conspiracy to hide  
6 Mr. Brockman's control over it. They also seized  
7 encrypted e-mail servers, which meant the Government  
8 was in possession of 14 years of encrypted, secret  
9 and highly incriminating conversations between  
10 Mr. Brockman and Mr. Tamine. To make matters worse,  
11 Mr. Tamine came in and signed an immunity with the  
12 Government and agreed to testify about his  
13 relationship with Mr. Brockman.

14 During the hearing, you are going  
15 to see a sampling of the documents contained on that  
16 server. You are going to see they make this case  
17 almost impossible to defend on the merits, and  
18 provide the motive for the Defendant to mangle his  
19 illness. You are going to see Mr. Tamine's formal  
20 performance reviews where he trumpets his ability to  
21 remain a figurehead of the trust while under the  
22 constant threat of detention. You will see clear  
23 evidence of the Defendant's control over the  
24 structure. You'll even see the Defendant telling  
25 Mr. Tamine he keeps old paper in his house to better

10:06:17 1 and more convincingly backdate documents.

10:06:21 2 So as you can see, to understand  
10:06:23 3 the Defendant's motivation to malingering, you have to  
10:06:26 4 understand the evidence against him. To understand  
10:06:30 5 the capacity for him to malingering, you also need to  
10:06:33 6 step back and look more broadly.

10:06:39 7 That part of the case is going to  
10:06:42 8 take us from basically the search warrant 2018,  
10:06:42 9 through his indictment of 2020. You will see the  
10:06:45 10 Defendant temporarily succeeds in duping a series of  
10:06:49 11 doctors about his mental condition, but that he does  
10:06:51 12 that while still living a remarkably  
10:06:55 13 high-functioning life.

10:06:55 14 So the search warrant happens on  
10:06:58 15 September 5, 2018. The next day while on a remote  
10:07:04 16 Alaskan fishing trip, the Defendant sends a detailed  
10:07:08 17 e-mail to his urologist seeking an appointment. You  
10:07:11 18 will learn that appointment happens the following  
10:07:13 19 week. At that appointment, the Defendant's  
10:07:16 20 urologist is the first doctor to notice anything  
10:07:19 21 wrong with the Defendant's mental health.

10:07:22 22 Now, in their reports, the Defense  
10:07:25 23 experts try to point to May 3, 2017, e-mail that the  
10:07:29 24 Defendant sent to Dr. Stuart Yudofsky. What they  
10:07:32 25 say in their reports is that that's evidence the

10:07:34 1 Defendant had symptoms prior to the warrant.

10:07:38 2 And the Defendant has even made  
10:07:40 3 that e-mail Defense Exhibit 1. But you are going to  
10:07:43 4 hear that despite being the recipient of more than  
10:07:46 5 \$25 million from the Defendant, after receiving that  
10:07:49 6 e-mail, Dr. Yudofsky did no examination, he ran no  
10:07:52 7 tests, he made no referral. He and the Defendant  
10:07:56 8 never even mentioned it to each other again until  
10:07:59 9 after the search warrant.

10:08:00 10 You will also hear from the Defense  
10:08:02 11 general practitioner, Dr. Scott Lisse. Dr. Lisse  
10:08:07 12 saw the Defendant multiple times between the  
10:08:09 13 Yudofsky e-mail and the search warrant. The  
10:08:12 14 Defendant does not raise any memory issues to  
10:08:15 15 Dr. Lisse. You'll hear the Defendant has planted  
10:08:19 16 correspondence in the past, including correspondence  
10:08:21 17 to Dr. Yudofsky.

10:08:25 18 Now, the urologist's observation of  
10:08:28 19 the Defendant sets off of a flurry of tests that  
10:08:31 20 bring us on the path we're on today. After he sees  
10:08:33 21 the urologist, he starts to be examined by a series  
10:08:36 22 of doctors all associated with Baylor University.  
10:08:39 23 Based on what he demonstrates in the exam room to  
10:08:42 24 those doctors, their diagnosis is very serious.  
10:08:46 25 They say it's either Lewy bodies or Parkinsonism

1 dementia. That's based on what he tells them in the  
2 exam room.

3                   You will hear that on January 30th,  
4 Dr. Joseph Jankovic concluded the Defendant was  
5 unable to respond accurately or appropriately to  
6 questions. He was unable to recall information. A  
7 couple months later on March 1, 2019, Defendant is  
8 examined by Dr. Michele York. During that exam he  
9 claims to not even be able to recognize the word  
10 "T-W-O," two. He doesn't recognize that as a word.  
11 He claims he's having a hallucination in the  
12 doctor's office with Dr. York.

13                   Based on that, Dr. York diagnoses  
14 him in March of 2019 with mild to moderate dementia.  
15 She says that the Defendant's processing speed is  
16 extremely slow, and she warns him to refrain from  
17 cooking or driving, because he could be a danger to  
18 himself or others.

19                   By December, the Defendant and his  
20 wife are back in front of Dr. York. They tell that  
21 it's gotten worse. In fact, by that point the  
22 Defendant can't use a remote control. He doesn't  
23 understand how to tie a tie. By the end of 2019,  
24 all of these doctors associated with Baylor  
25 University have concluded that the Defendant has

10:10:04 1 dementia severe enough that he's not competent to  
10:10:07 2 stand trial.

10:10:09 3 Why did they deliver such serious  
10:10:12 4 diagnoses? Because they were doing what any  
10:10:14 5 reasonable doctor would do, they would trust that  
10:10:18 6 their patient was telling them the truth. But as  
10:10:21 7 you are going to see over the next few days, sadly  
10:10:24 8 that's not an assumption you can make when it comes  
10:10:26 9 to this patient.

10:10:29 10 What you are going to see is that  
10:10:30 11 the picture he's painting inside the exam rooms is  
10:10:33 12 entirely inconsistent with the life he continues to  
10:10:36 13 lead outside the doctor's office.

10:10:38 14 Two weeks before Dr. Jankovic  
10:10:41 15 concludes the Defendant is unable to respond  
10:10:44 16 appropriately to questions or recall information.  
10:10:45 17 You are going to hear that he sat for two days of  
10:10:47 18 testimony in a complex anti-trust matter. We're  
10:10:52 19 going to show you video of that deposition, and you  
10:10:54 20 will hear from the attorney that took it.

10:10:57 21 That attorney will tell you he  
10:10:59 22 never got any sign that the Defendant was unable to  
10:11:02 23 speak accurately, and that he -- that -- sorry, that  
10:11:07 24 are there was no sign that he -- any inability to  
10:11:10 25 speak accurately, and he's going to tell you that he

10:11:12 1 viewed the Defendant as among the strongest people  
10:11:15 2 he had ever deposed.

10:11:17 3 Now, March 1st again is when  
10:11:22 4 Dr. York first diagnoses the Defendant with  
10:11:24 5 dementia. Six months after that diagnosis -- six  
10:11:28 6 months after the Defendant can't recognize the word  
10:11:31 7 two, and is having hallucinations in the exam room,  
10:11:34 8 he sits for another two-day deposition in an FTC  
10:11:38 9 proceeding. You'll hear that at that proceeding,  
10:11:41 10 neither the Defendant nor his lawyers raised any  
10:11:44 11 concerns with his ability to proceed.

10:11:45 12 They did not tell the FTC lawyers  
10:11:48 13 he had been diagnosed with dementia, and that for  
10:11:50 14 two days he answered questions, he reviewed e-mails,  
10:11:53 15 he gave substantive answers in that deposition.

10:11:57 16 And while the Defendant is telling  
10:11:59 17 Dr. York he can't tie a tie or understand how to use  
10:12:02 18 a remote control, you'll see from his own e-mails  
10:12:05 19 he's continuing to use guns throughout 2019 and  
10:12:09 20 2020, including shotguns and assault rifles.

10:12:13 21 Most significantly, the evidence is  
10:12:15 22 going to show that despite these diagnoses, despite  
10:12:18 23 what he's telling doctors and lawyers, the Defendant  
10:12:21 24 is remaining at the helm of his 5,000-person,  
10:12:24 25 multibillion dollar international software company.

10:12:27 1 You will hear from two of his executives. And  
10:12:30 2 they'll tell you, sure, the Defendant was aging.  
10:12:33 3 "We noticed signs of that," but he was not showing  
10:12:36 4 the serious incapacity that the Defendant was  
10:12:40 5 claiming to his doctors.

10:12:41 6 You will also see he doesn't remain  
10:12:44 7 at the helm of his company simply out of inertia.  
10:12:48 8 In June of 2020, 15 months after Dr. York's  
10:12:50 9 diagnosis, two months after the Defendant's  
10:12:53 10 attorneys tell the Government he is so incapacitated  
10:12:56 11 he shouldn't even be indicted, the Defendant  
10:12:59 12 reorganizes the entire executive leadership of the  
10:13:01 13 company. He moves certain executives up to  
10:13:04 14 president, and moves others around and creates an  
10:13:07 15 executive committee. But despite this  
10:13:10 16 re-organization, despite what he's telling his  
10:13:12 17 doctors and lawyers, the Defendant is remaining as  
10:13:15 18 chairman and CEO. He remained in that role until  
10:13:19 19 after his indictment was unsealed in this case.

10:13:21 20 It is clear from the Defendant's  
10:13:23 21 life outside the exam room that he's deceiving the  
10:13:26 22 doctors inside the exam room, and that he has the  
10:13:31 23 ability to deceive even trained medical  
10:13:33 24 professionals about his true cognitive ability.

10:13:39 25 I think it'll be clear to you by

1 November of 2020, the Defendant demonstrated both  
2 the motivation and capacity to malingering. Our  
3 experts are going to tell you that you have to  
4 consider that when evaluating his performance on the  
5 medical exam that the Court ordered in this case,  
6 and that makes sense. The Defendant wants to show  
7 you just narrowly what's happening in the exam room.  
8 That's the only thing you should consider.

9 He wants you to narrow your focus,  
10 because if you do that you'll find the same thing  
11 they did. You'll give the Defendant a diagnosis  
12 based on his deception. But we're going to show you  
13 imaging of the Defendant's brain. It's one of the  
14 only pieces that you can't fake; right? It's like  
15 an objective medical test. And our experts will say  
16 while they indicate early signs of Alzheimer's  
17 disease, they're inconsistent with the advanced,  
18 severe dementia the Defendant is trying to portray.

19 Our experts are also going to ask  
20 you to look at the timeline in this case. You'll  
21 see that the Defendant's cognitive test scores from  
22 2019 through 2021 are remarkably consistent. Our  
23 experts are going to tell you that doesn't really  
24 make a lot of sense. Because if the Defendant truly  
25 has progressive dementia, his test scores should be

10:14:54 1 getting worse.

10:14:55 2 He should be scoring worse on  
10:14:57 3 cognitive tests in 2021 than he was scoring in 2019  
10:15:00 4 when he's sitting for depositions giving speeches  
10:15:02 5 and running his company, but that's not what  
10:15:04 6 happened. The test scores remained the same,  
10:15:08 7 because the Defendant is faking the results.

10:15:11 8 You'll hear testimony and see video  
10:15:13 9 about the Defendant's May, 2021 exam by the  
10:15:16 10 Government's experts. They'll tell you once again  
10:15:20 11 the Defendant's performance on psychiatric tests was  
10:15:22 12 totally inconsistent with his real-world  
10:15:26 13 performance. Dr. Robert Denney did the psychiatric  
10:15:29 14 exams in this case. He tested the Defendant on  
10:15:31 15 May 2021.

10:15:33 16 He's going to tell you the  
10:15:34 17 Defendant's performance was implausibly poor. That  
10:15:37 18 on one exam, the Defendant did worse than he would  
10:15:40 19 have done 92 times out of a 100 if he had been  
10:15:43 20 blindfolded. On another exam, the Defendant scored  
10:15:47 21 worse than -- on a a demographic and age-adjusted  
10:15:50 22 basis than 99.9 percent of patients.

10:15:53 23 That on a memory test, the  
10:15:56 24 Defendant got the lowest score Dr. Denney has ever  
10:15:59 25 seen in 21 years of administering the test. You'll

10:16:02 1 hear from the Government's experts that these scores  
10:16:06 2 are so low that it's almost impossible the Defendant  
10:16:09 3 was not exaggerating his symptoms.

10:16:11 4 We're going to show you video of  
10:16:13 5 that test. The interview portion that was conducted  
10:16:16 6 the same day. You will see the Defendant is in  
10:16:19 7 control of the facts. He talked about the case. He  
10:16:21 8 talks about the possible defenses. He raises the  
10:16:23 9 potential defenses to the case on his own.

10:16:26 10 He'll say the cooperators are lying  
10:16:29 11 to try to save their necks. He's going to say that  
10:16:30 12 Mr. Tamine manufactured the documents that were  
10:16:32 13 given to the Government, or that other documents say  
10:16:34 14 that the Defendant's not in control of the trust.  
10:16:37 15 These are not the statements of a person who is so  
10:16:41 16 incapacitated he needs almost constant care.

10:16:45 17 That's what Dr. Denney and  
10:16:48 18 Dr. Dietz are going to tell you are what his scores  
10:16:50 19 are purportedly showing. His competence in May is  
10:16:54 20 going to be nearly impossible to dispute, and our  
10:16:57 21 experts will tell you that that's important for two  
10:16:59 22 reasons.

10:17:00 23 First, if he's competent in May,  
10:17:02 24 that means he managed to fool all of the doctors and  
10:17:04 25 lawyers that said he was incompetent for years prior

10:17:08 1 to that exam.

10:17:10 2 Second, his condition in May is  
10:17:13 3 instructive of his condition today. These diseases  
10:17:16 4 have well-known progressions, and the Defendant --  
10:17:21 5 what the Defendant is trying to portray to this  
10:17:23 6 Court is simply inconsistent with a known path that  
10:17:25 7 these diseases take.

10:17:27 8 Now, following that exam, the  
10:17:29 9 Government experts -- they write-up their findings.  
10:17:31 10 They say why they believe the Defendant is faking,  
10:17:34 11 and how they intend to demonstrate that he's faking.  
10:17:37 12 They write it in a report that's given over to the  
10:17:40 13 Defendant. Now, after he gets that report, he's  
10:17:44 14 examined again by his doctors in July.

10:17:46 15 You will see the performance on the  
10:17:48 16 May exam versus the July exam are 180 degrees  
10:17:51 17 different. And, Judge, to be clear, the Defendant  
10:17:55 18 was hospitalized in June. So what you are going to  
10:17:57 19 have to decide by the end of the hearing is whether  
10:18:00 20 his more recent performance is a genuine decline  
10:18:03 21 because of that hospitalization, or if the Defendant  
10:18:05 22 realized he didn't fool the Government's experts, so  
10:18:09 23 he's going to have to step his game up. The  
10:18:12 24 Government experts will tell you why they believe  
10:18:14 25 it's the second one, why they believe the Defendant

10:18:17 1 continues to malingering.

10:18:18 2 First, the Defendant is going to  
10:18:20 3 continue to fail what are called internal-validity  
10:18:23 4 tests, or malingering tests, throughout October.  
10:18:25 5 These tests are designed to determine the amount --  
10:18:28 6 whether a person is giving a genuine effort on the  
10:18:30 7 rest of the psychiatric tests. The Defendant failed  
10:18:33 8 the tests given by Dr. Denney in May and October,  
10:18:36 9 and even failed the tests given by his own experts  
10:18:39 10 in July. And one of the things you are going to  
10:18:41 11 hear is these are designed to have a low, false  
10:18:43 12 positive rate. So the fact that he's failing these  
10:18:45 13 tests at all is indicative of the fact that he's not  
10:18:47 14 giving his full effort.

10:18:50 15 Second our experts are going to  
10:18:51 16 tell you the progression of the Defendant's alleged  
10:18:53 17 symptoms are inconsistent with genuine illness.

10:18:58 18 Third, the fact that the Defendant  
10:19:00 19 continues to exaggerate his symptoms, even today, is  
10:19:04 20 itself evidence of the fact that he is competent to  
10:19:06 21 stand trial. Over the course of this week, the  
10:19:11 22 Defendant will ask you to focus only on what happens  
10:19:13 23 in the exam.

10:19:14 24 We ask you to take a broader view.  
10:19:17 25 Unlike his doctors, do not take the Defendant's

10:19:20 1 words simply at face value. We're going to ask you  
10:19:22 2 to look at the whole picture of his years of  
10:19:24 3 deceitful conduct about his medical symptoms. And  
10:19:28 4 the evidence is going to show when you do that, the  
10:19:32 5 Defendant had the motivation to malingering, the  
10:19:34 6 capacity to malingering, and is malingering.

10:19:37 7 Thank you, Your Honor.

10:19:38 8 THE COURT: Thank you, Counsel.

10:19:50 9 MS. KENEALLY: Good morning, Your  
10:19:51 10 Honor.

10:19:51 11 THE COURT: Good morning. You may  
10:19:52 12 proceed when ready.

10:19:54 13 MS. KENEALLY: Thank you. Before I  
10:19:55 14 start, I do want to introduce one more person in the  
10:19:57 15 courtroom, Mrs. Dorothy Brockman is in the row  
10:20:03 16 behind the well of the Court. Mrs. Brockman will  
10:20:07 17 not be able to stay through the proceedings. Her  
10:20:09 18 doctor has recommended that she not subject her back  
10:20:12 19 to the court seats.

10:20:14 20 Um, but I did want to introduce --  
10:20:24 21 sorry, I'm Kathy Keneally, and I have represented  
10:20:27 22 Mr. Brockman since 2018, along with my firm.

10:20:30 23 THE COURT: Okay.

10:20:31 24 MS. KENEALLY: There's only one issue  
10:20:33 25 before the Court at this hearing, can Bob Brockman

10:20:37 1 today understand the criminal proceedings brought  
10:20:40 2 against him and assist his counsel in his defense.

10:20:46 3 The Supreme Court said in *Dusky v*  
10:20:48 4 *United States*, does Bob have the sufficient  
10:20:52 5 presentability to consult with his lawyers with a  
10:20:54 6 reasonable degree of rational understanding? Can  
10:20:58 7 Bob today going forward participate in a meaningful  
10:21:01 8 way in his defense?

10:21:02 9 He cannot. I agree with the  
10:21:05 10 Government. This is a complicated case. It's the  
10:21:08 11 most complicated tax case I've ever seen. The  
10:21:11 12 charges in the indictment cover nearly 40 years.  
10:21:14 13 The allegations, again as the Government says, track  
10:21:18 14 back to a trust, The A. Eugene Brockman Charitable  
10:21:22 15 Trust -- which I usually hear referred to as the  
10:21:25 16 "AEBCT" -- Bob's father settled in 1981.

10:21:29 17 There's nothing wrong with setting  
10:21:30 18 up a trust like The A. Eugene Brockman Charitable  
10:21:33 19 Trust. We talk a lot about offshore trusts, but  
10:21:36 20 this trust is of a kind that is used by state  
10:21:39 21 players. And they talk about offshore assets, but  
10:21:44 22 the main asset of this trust is the Reynolds and  
10:21:48 23 Reynolds Company, and this corporate structure above  
10:21:50 24 the Reynolds and Reynolds Company which are all US  
10:21:54 25 companies. This is a company -- they talk about the

10:21:56 1 thousands of people that work for the company.

10:21:58 2 Those people work in Houston and Dayton, Ohio.

10:22:07 3 Tax crimes are different from most  
10:22:09 4 other crimes. The criminal statutes require proof  
10:22:12 5 of specific intent, voluntary and intentional  
10:22:14 6 violation of a known-legal duty. There are defenses  
10:22:18 7 to the charges in the indictment. To some degree, I  
10:22:21 8 felt like I was hearing the opening statement of the  
10:22:23 9 trial itself this morning. Bob can't help us in  
10:22:29 10 making those defenses. Bob can't defend himself.

10:22:37 11 Bob Brockman has dementia. Bob  
10:22:41 12 doesn't remember what I tell him from one call to  
10:22:43 13 the next. I've explained legal issues to Bob and  
10:22:46 14 he's agreed to a course of action, and then three  
10:22:50 15 days later he didn't remember the discussion or the  
10:22:53 16 decision.

10:22:56 17 I've talked with Bob with each  
10:22:57 18 conference, before and after the Court while on the  
10:22:59 19 screen. I talked to him before and tell him what's  
10:23:01 20 going to happen. I speak to him after. He doesn't  
10:23:04 21 remember what I told him ahead of the conference.  
10:23:07 22 He doesn't understand what happened.

10:23:11 23 The Government talks about the  
10:23:14 24 timeline, talks about the events of 2019, the search  
10:23:20 25 warrant, the phone calls, the trip. We're not in

10:23:25 1 2019. We're in late 2021.

10:23:28 2 Again, the question is can Bob  
10:23:31 3 Brockman assist today going forward through trial in  
10:23:34 4 this case? There are some things the medical  
10:23:39 5 witnesses agree on, on both sides. They agree that  
10:23:42 6 Bob Brockman has Parkinson's disease. Parkinson's  
10:23:46 7 is a progressive, neurodegenerative disease.  
10:23:52 8 Parkinson's does not equate to dementia, but experts  
10:23:54 9 will tell you dementia is a very common symptom of  
10:23:57 10 Parkinson's.

10:23:58 11 In addition to Parkinson's  
10:23:59 12 dementia, experts will testify this week and tell  
10:24:02 13 the Court there's objective neuroimaging that  
10:24:05 14 supports that Bob also has Alzheimer's dementia.  
10:24:08 15 Alzheimer's dementia, like Parkinson's, is  
10:24:11 16 permanent, progressive and incurable. Experts on  
10:24:17 17 both sides agree that Bob has some degree of  
10:24:20 18 cognitive impairment.

10:24:21 19 The experts agree it's progressive,  
10:24:26 20 and experts on both sides agree it's progressed. If  
10:24:30 21 you look at the expert reports, they agree it's  
10:24:32 22 gotten worse from the time he was examined in May,  
10:24:35 23 to the time he was examined in October.

10:24:38 24 Now, the -- Mr. Langston spoke  
10:24:42 25 about the tests that were done in July. If the

10:24:45 1 Court remembers, we were here in July. We said Bob  
10:24:48 2 had recently been hospitalized for sepsis, which  
10:24:51 3 resulted in delirium. We raised the issues, are  
10:24:56 4 those tests going to be affected by that  
10:24:58 5 hospitalization? We're not here talking about the  
10:25:00 6 July tests. He's been reexamined by both sides in  
10:25:04 7 October.

10:25:06 8 So there's been progression, and  
10:25:07 9 progression from May to October. Nobody's here  
10:25:10 10 saying -- happened immediately after the sepsis and  
10:25:16 11 delirium.

10:25:18 12 Well, it's happening today. So the  
10:25:24 13 issue is Bob's current cognitive limitations. The  
10:25:26 14 Government says he's exaggerating. Not that he  
10:25:29 15 isn't to some degree impaired, but they contend from  
10:25:32 16 an already-impaired state he's faking or  
10:25:35 17 exaggerating symptoms. Not that Bob Brockman of  
10:25:38 18 five or ten years ago, but Bob Brockman who already  
10:25:42 19 has Parkinson's, and some degree of cognitive  
10:25:45 20 impairment -- they're saying still he's faking it.

10:25:48 21 One of the Government's experts  
10:25:51 22 acknowledges that for Bob to fool multiple and  
10:25:54 23 treating physicians, along with friends, family and  
10:25:58 24 lawyers, would be a Herculean task. The objective  
10:26:03 25 evidence refutes this is what's happening.

10:26:05 1 There are neuroimaging reports.  
10:26:08 2 We're going to talk a lot I'm sure over the next  
10:26:10 3 week about the neuroimaging reports. The  
10:26:13 4 neuroimaging reports show results consistent with  
10:26:16 5 Alzheimer's. In many cases, the cause of dementia  
10:26:20 6 is elusive, and can only be determined postmortem.

10:26:24 7 That's not this case. In Bob's  
10:26:26 8 case, we have concrete, objective, cannot-be-faked  
10:26:32 9 neuroimaging reports. In addition to the  
10:26:37 10 neuroradiology experts -- both sides have  
10:26:42 11 neuroradiologist experts -- the doctors who analyze  
10:26:45 12 the PET scans, those doctors -- both sides plan to  
10:26:48 13 call neuropsychiatrists and psychiatrists as  
10:26:51 14 witnesses. So I'm going to take a few minutes to  
10:26:53 15 talk about other specialists and get back to the  
10:26:56 16 neuroradiologists.

10:26:57 17 Medical experts that the Defense  
10:27:01 18 will call address the questions each from those  
10:27:06 19 specialities: Neuropsychology, psychiatry,  
10:27:11 20 neurology. They come to the same conclusion.

10:27:17 21 Dr. Wisniewski, a neurologist who  
10:27:17 22 is the director of the Alzheimer's Disease Center  
10:27:21 23 NYU will testify that Bob has Parkinson's disease  
10:27:25 24 dementia and co-occurring Alzheimer's disease. In  
10:27:29 25 other words, dementia resulting from Parkinson's

10:27:31 1 disease, and at the same time dementia resulting  
10:27:33 2 from Alzheimer's.

10:27:34 3 Dr. Wisniewski will testify that  
10:27:37 4 Bob's dementia is at a level that it significantly  
10:27:40 5 impairs all activities of daily living, not just  
10:27:44 6 working with us on this case.

10:27:48 7 Dr. Guilmette, a neuropsychologist  
10:27:53 8 that we will call, agrees that Bob has Parkinson's  
10:27:55 9 dementia. He bases his conclusion on his  
10:27:58 10 examination and neuropsychological testing of Bob  
10:28:02 11 that's in the exam room. He also relies on the  
10:28:06 12 concrete evidence of the neuroimaging.

10:28:08 13 Dr. Guilmette, in his report,  
10:28:10 14 stated that structural and functional neurodata --  
10:28:14 15 neuroimaging data, which cannot be faked, provides  
10:28:18 16 additional confirmation Mr. Brockman suffers from  
10:28:23 17 genuine neurodegenerative disease -- not faking it.

10:28:26 18 Dr. Agronin, the psychiatrist the  
10:28:29 19 Defense will call, specializes in treating geriatric  
10:28:33 20 patients with neurocognitive disorders. He  
10:28:37 21 diagnosed Bob with Parkinson's dementia and possible  
10:28:40 22 comorbidity for Alzheimer's dementia.

10:28:42 23 The medical experts rely on their  
10:28:45 24 examinations of Bob. They also rely on interviews  
10:28:50 25 of Bob's wife, caregiver, friends, business

10:28:53 1 colleagues and lawyers. They rely on objective --  
10:28:57 2 medical imaging data.

10:29:00 3 So I'll talk for a few minutes  
10:29:02 4 about the Government's experts. The Government  
10:29:04 5 retained a neurologist, Dr. Ryan Darby. You've  
10:29:08 6 heard about Dr. Darby, and we expect to hear from  
10:29:14 7 him today. Dr. Darby, in his supplemental report,  
10:29:17 8 actually stated -- again, Bob was examined in May,  
10:29:20 9 and then again by all of the experts in October. In  
10:29:24 10 May by the Government, and then all of the experts  
10:29:26 11 in October.

10:29:27 12 He said that even Bob's recurring  
10:29:31 13 history of hospitalization for delirium --  
10:29:34 14 hospitalization this year for delirium, the natural  
10:29:37 15 course of his disease, and the neuroimaging that  
10:29:40 16 it's reasonable to conclude Bob has progressed to  
10:29:45 17 the dementia state. Then in his report we'll see  
10:29:50 18 what he sees here, but in his report he says that  
10:29:53 19 he's unable to determine whether Bob's cognitive  
10:29:55 20 impairment is severe enough to make him incompetent  
10:29:59 21 to assist in his defense. That's the sole issue  
10:30:02 22 before the Court.

10:30:06 23 The Government's neurologist in his  
10:30:08 24 report has said that it is reasonable to conclude  
10:30:11 25 Bob has dementia, and that he does not know whether

10:30:14 1 Bob's dementia has reached the stage where he cannot  
10:30:16 2 assist in his defense. Dr. Darby also makes it  
10:30:21 3 clear we're only going in one direction here. As I  
10:30:24 4 said earlier, Parkinson's disease dementia and  
10:30:26 5 Alzheimer's dementia are progressive.

10:30:31 6 Dr. Darby concludes Bob is at  
10:30:33 7 increased risk of progression over time. It's going  
10:30:36 8 to get worse from here, due to his history of  
10:30:39 9 delirium. The Government has the burden of proof on  
10:30:43 10 the issue of Bob's competency. Dr. Darby's  
10:30:46 11 basically saying that in his medical opinion, their  
10:30:50 12 expert -- that that burden can't be met.

10:30:53 13 Again, from the beginning -- from  
10:30:54 14 the very beginning, the Government's position has  
10:30:57 15 been that Bob is malingering, faking his symptoms to  
10:31:01 16 avoid prosecution in everything they file.

10:31:05 17 The key witness for the Government  
10:31:06 18 on this issue is Dr. Robert Denney, a  
10:31:09 19 neuropsychologist who spent 20 years conducting  
10:31:12 20 examinations and testifying on behalf of the Bureau  
10:31:15 21 of Prisons. Dr. Denney's conclusion, and listening  
10:31:19 22 -- we'll all listen to Dr. Denney -- is based on his  
10:31:22 23 subjective interpretation of certain tests that he  
10:31:25 24 performed and his personal observations of Bob.

10:31:28 25 He makes reference in his reports

10:31:30 1 to other testing and to Bob's medical history, but  
10:31:34 2 glosses over or dismisses information in favor of  
10:31:38 3 the subjective interpretation of his own testing,  
10:31:40 4 and similarly dismisses Bob's life today, including  
10:31:45 5 his wife and his attorneys.

10:31:48 6 Then the Government's next witness,  
10:31:50 7 the psychiatrist -- right -- neurologist --  
10:31:54 8 neuropsychologist is Dr. Dietz, a forensic  
10:32:00 9 psychologist. Dr. Dietz -- Dr. Dietz has actually  
10:32:04 10 had three different expert reports, three different  
10:32:07 11 opinions. The first report -- the one filed in June  
10:32:11 12 based on the examinations in May found not com --  
10:32:16 13 competent.

10:32:16 14 In his supplemental report,  
10:32:18 15 Dr. Dietz said he could not -- supplemental report  
10:32:21 16 Dr. Dietz said that the brain imaging studies, the  
10:32:24 17 PET scans are the most objective evidence, and he  
10:32:27 18 acknowledged that they are consistent with  
10:32:29 19 Alzheimer's. At that point, he's in agreement with  
10:32:33 20 the Defense's experts. He also acknowledged that  
10:32:39 21 Bob's recent infections and episodes of delirium --  
10:32:43 22 again events of this year -- this is a quote, "Throw  
10:32:46 23 into question Mr. Brockman's current cognitive  
10:32:48 24 abilities, and those aspects of competence to stand  
10:32:51 25 trial that require short-term memory."

1 That's their expert. And it's  
2 Dr. Dietz -- and we raised this with the Court  
3 previously, it's Dr. Dietz who said to be faking it  
4 at this level -- for Bob to be faking and his  
5 treating doctors, doctors at Baylor, Houston  
6 Methodist, family, friends, lawyers, would be a  
7 Herculean task.

8 Dr. Darby -- Dr. Dietz's  
9 supplemental report also said he couldn't reach  
10 vital conclusion. Five days later, Dr. Dietz  
11 changed his mind issuing an opinion that he had  
12 recently reviewed Dr. Denney's supplemental report,  
13 and essentially adopts its conclusions. In other  
14 words, Dr. Dietz's conclusions result on  
15 Dr. Denney's conclusions.

16 Dr. Dietz is a high-profile,  
17 somewhat what of a celebrity witness. He's  
18 testified in a number of high-profile insanity  
19 cases. It's our submission that he's not a  
20 geriatric psychiatrist. This is not his field of  
21 expertise. He doesn't reach a conclusion in one  
22 report, and the next report he switches to rely on  
23 Dr. Denney's conclusion.

24 So as promised, that brings me back  
25 to the neuroradiologist. Again, that's where I

10:34:15 1 think both sides agree can't be faked to the image  
10:34:19 2 of the brain.

10:34:20 3 Dr. Christopher Whitlow, our  
10:34:23 4 expert, looked at the neuroimaging studies of Bob's  
10:34:27 5 Brain. Both parties ordered -- asked for a number  
10:34:30 6 of them. He focused on three. Two of them are  
10:34:38 7 FDG-PET scans that Government asked for in March.  
10:34:43 8 One is an amyloid PET scan done in July.

10:34:46 9 They form the basis of his opinion  
10:34:49 10 that Bob has Alzheimer's disease, as well as  
10:34:51 11 Parkinson's disease dementia, it's objective  
10:34:54 12 neuroimaging.

10:34:55 13 Historically -- I think we know  
10:35:01 14 this -- the causes of dementia could not be  
10:35:03 15 determined in many cases in a living patient, but  
10:35:08 16 there's a body of data now available from postmortem  
10:35:11 17 studies where you can compare the tests done now  
10:35:14 18 with -- with what you can learn from the postmortem  
10:35:18 19 studies.

10:35:19 20 There's a recent significant study  
10:35:21 21 Dr. Whitlow will discuss that show when the results  
10:35:24 22 of an amyloid PET scan and FDG-PET for the same  
10:35:29 23 individual in combination show results consistent  
10:35:31 24 with Alzheimer's that there's -- those results  
10:35:34 25 correlate nearly 100 percent with the postmortem

10:35:38 1 studies of patients with Alzheimer's.

10:35:40 2 Now, I'm going to leave it to  
10:35:43 3 Dr. Whitlow to explain what an amyloid PET scan and  
10:35:46 4 an FDG-PET scan is, and how if you look at the two  
10:35:49 5 of them together the key point is that the results  
10:35:52 6 of PET scans done on Bob's brain show objective  
10:35:56 7 results that he has Alzheimer's disease. Again,  
10:36:00 8 progressive and incurable.

10:36:01 9 The Government -- we talked about  
10:36:05 10 Dr. Ponisio this morning whether she'll be called as  
10:36:07 11 a witness or not. The reason there's been  
10:36:10 12 discussion about Dr. Ponisio, their expert, is that  
10:36:12 13 her report says that the neuroimaging data is also  
10:36:18 14 consistent with a finding of Alzheimer's dementia.  
10:36:20 15 There's a lot of lining up here on what's going on.  
10:36:25 16 That's a lot of medical evidence about how Bob is  
10:36:30 17 today. In response, the Government wants us to look  
10:36:32 18 backwards.

10:36:33 19 The Government's witness list  
10:36:36 20 includes Evatt Tamine -- I've always known it as  
10:36:42 21 Tamine, but Evatt Tamine is individual one in the  
10:36:47 22 indictment. The Government's acknowledged that. He  
10:36:49 23 also has had no communication with Mr. Brockman for  
10:36:52 24 over three years.

10:36:53 25 Another witness is Craig Moss, the

10:36:57 1 former CFO of Reynolds and Reynolds, company in  
10:37:00 2 Houston and Ohio, a company from which Bob fully  
10:37:05 3 retired a year ago. And there's Michael Nemelka and  
10:37:09 4 Dana Abrahamsen, two attorneys who deposed Bob in  
10:37:12 5 2019.

10:37:13 6 The Government recently did add  
10:37:15 7 Dr. Scott Lisse, again a doctor who has not seen Bob  
10:37:19 8 in three years, and apparently doesn't remember.  
10:37:24 9 These witnesses cannot answer the question, how is  
10:37:26 10 Bob today, today and going forward? Can Bob  
10:37:30 11 understand the criminal proceedings brought against  
10:37:32 12 him and assist us in his defense?

10:37:37 13 The Government talks about the exam  
10:37:38 14 room. It's not just the exam room. The Defense  
10:37:42 15 will call testimony from people on Bob's side today.  
10:37:49 16 There's Dr. Eugene Lai, director of the  
10:37:52 17 Neurodegenerative Disease Clinic at Houston  
10:37:56 18 Methodist. There's been some question about Bob's  
10:37:59 19 donations to Baylor, and whether that -- whether  
10:38:03 20 those donations actually come from Bob or the trust.

10:38:07 21 Put that aside. Dr. Lai is at  
10:38:09 22 Houston Methodist. He's Bob's treating physician  
10:38:12 23 today for Parkinson's. He was originally on our  
10:38:15 24 list and the Government's list as a witness. He  
10:38:18 25 examined Bob in early October. He diagnosed

10:38:20 1 dementia. He came off their witness list.

10:38:24 2 Then the remaining medical expert  
10:38:26 3 that will be called is Dr. James Pool. He's on both  
10:38:32 4 sides' lists. He's Bob's primary care physician.

10:38:37 5 Turning to the people who are in  
10:38:40 6 Bob's life. Dementia is insidious. Steals  
10:38:51 7 memories. Undercuts ability to reason, and it  
10:38:55 8 pervades a person's life. That's what we're talking  
10:38:58 9 about here.

10:38:58 10 Dementia doesn't manifest the same  
10:39:01 11 way in every individual. Bob's case -- he may still  
10:39:05 12 appear able to carry on a conversation, talk about  
10:39:09 13 long ago events, or the company he built and ran for  
10:39:12 14 decades. Doctors are going to tell you this week  
10:39:15 15 that does not mean he can currently understand,  
10:39:18 16 reason, or remember.

10:39:20 17 This is something -- the doctor's  
10:39:22 18 are going to explain medical terms, but this is also  
10:39:25 19 something that the people close to Bob can describe,  
10:39:28 20 people outside the exam room. Defense plans to call  
10:39:34 21 Frank Gutierrez. The parties have agreed  
10:39:37 22 Mr. Gutierrez is here in the courtroom. He's Bob's  
10:39:40 23 caregiver. He sees him on a daily basis.

10:39:44 24 He can speak to how Bob forgets  
10:39:46 25 where he is, how he thinks the house he lives in is

10:39:49 1 not his home, but that his real home is some other  
10:39:53 2 place people are keeping secret from him. How he  
10:39:56 3 gets up and starts to get ready for work at a job he  
10:39:59 4 hasn't held in over a year. How he packs for  
10:40:03 5 fishing trips that nobody can take him on anymore.  
10:40:08 6 That's what Mr. Gutierrez will tell you about.

10:40:10 7 Defense also plans to call Reverend  
10:40:14 8 Jackson. Reverend Jackson has known Bob since 1994.  
10:40:18 9 They first met when Bob was a congregante in his  
10:40:23 10 church. Mr. Jackson went to work for Reynolds and  
10:40:26 11 Reynolds, the company we talked about, the US  
10:40:29 12 company owned by this trust. Serving as executive,  
10:40:35 13 he can speak to how he's watched Bob's physical and  
10:40:39 14 mental deterioration and the impact on Bob's life  
10:40:42 15 today.

10:40:42 16 Defense also plans to call Stephen  
10:40:46 17 Slade. Not another medical witness, but somebody  
10:40:49 18 who has known Bob for over 30 years. They were  
10:40:53 19 fishing buddies. They're friends today. Dr. Slade  
10:40:57 20 has watched Bob's dementia progress, and can explain  
10:41:01 21 how his friend is becoming lost to him and also to  
10:41:05 22 himself.

10:41:06 23 So the people in Bob's life today,  
10:41:08 24 not in the exam room -- these are people who see  
10:41:11 25 him. This is the man who takes care of him.

10:41:15 1 I need to mention one other  
10:41:17 2 potential witness. On Friday, the Government told  
10:41:19 3 us for the first time they had a Tommy Barris  
10:41:24 4 (phonetic) to their witness list. One fact witness  
10:41:26 5 on their list who has seen Bob this year. If the  
10:41:31 6 Government actually calls Tommy Barris, ask the  
10:41:35 7 Court to listen to what he has to say about how Bob  
10:41:37 8 is today.

10:41:38 9 I'm going to end where I started.  
10:41:43 10 Objective evidence -- neuroimaging report shows that  
10:41:46 11 Bob has dementia. The witnesses who have seen Bob  
10:41:50 12 this year in the last few months -- last few days --  
10:41:54 13 treating doctors, friends, caregiver and his lawyers  
10:41:59 14 corroborate what the Defense medical experts will  
10:42:02 15 tell you. Bob's dementia -- again, progressive,  
10:42:07 16 incurable, has gone beyond the point where he can  
10:42:09 17 assist in his defense.

10:42:12 18 The right to defend oneself in a  
10:42:17 19 criminal case is fundamental to due process and to  
10:42:22 20 other constitutional rights. As attorneys, we need  
10:42:27 21 Bob to understand -- to help us understand the  
10:42:30 22 complex structures and transactions that spanned  
10:42:33 23 nearly 40 years, to assist us in understanding  
10:42:37 24 documents and statements of other witnesses, and to  
10:42:38 25 put those things in context, to follow the

10:42:41 1 proceedings in the court, to recognize discrepancies  
10:42:45 2 in witness testimony, and fundamentally be able to  
10:42:48 3 provide testimony or to make the decision not to  
10:42:51 4 testify.

10:42:54 5 So we as lawyers need from our  
10:42:56 6 client -- and that's what he has a right to offer in  
10:42:59 7 his defense. As I described at the beginning, Bob  
10:43:06 8 can't follow these proceedings. He's past being  
10:43:09 9 able to understand what it means to testify, let  
10:43:11 10 alone remember that he made the decision whether to  
10:43:14 11 testify or not. Bob Brockman can't defend himself.  
10:43:20 12 Dementia has stolen that from him and much more.

10:43:25 13 Thank you.

10:43:25 14 THE COURT: Thank you, Counsel.

10:43:34 15 Government may call its first  
10:43:36 16 witness.

10:43:37 17 MR. MAGNANI: Thank you, Your Honor.  
10:43:38 18 The United States calls Dr. Ryan Darby.

10:43:40 19 THE COURT: Okay. Dr. Darby, if you  
10:43:43 20 could step forward. Good morning, if you could  
10:43:51 21 raise your right hand, Dr. Darby.

10:43:53 22  
23 ///

24 ///

25 ///

**RYAN DARBY,**

**(For the Government)**

called as a Witness, having been duly  
and regularly sworn, testified as follows:

THE WITNESS: I do.

THE COURT: You may take the stand,  
sir.

**DIRECT EXAMINATION**

**BY MR. MAGNANI:**

**Q.** Thank you, Your Honor.

Dr. Darby, what do you do for a  
living?

**A.** I'm a behavioral neurologist.

**Q.** What is that?

**A.** Well, it's -- it's two things, actually. So as  
a neurologist, I see and evaluate patients with  
diseases of the nervous system. So that includes  
everything extending from the peripheral nerves in  
the body, through the spinal cord and into the  
brain.

And then, as a behavioral  
neurologist I specialize in cognitive disorders, so  
disorders that affect thinking, memory, language,  
decision-making.

**Q.** What education qualifies you to be a behavioral

10:45:01 1 neurologist?

10:45:02 2 **A.** Well, I first received degree in psychology and  
10:45:06 3 neuroscience from Princeton, and that's where my  
10:45:09 4 interests in the nervous system began. Then went to  
10:45:11 5 medical school at Vanderbilt, where I received my  
10:45:14 6 training in medical education and specialized in  
10:45:17 7 neurology.

10:45:18 8 So I did a three-year residency  
10:45:20 9 program at the Harvard Massachusetts General and  
10:45:24 10 Brigham Women's Hospital Program. This is where I  
10:45:26 11 really learned how to diagnose and manage patients  
10:45:29 12 with diseases that can affect the nervous system, so  
10:45:32 13 that includes everything from strokes, tumors,  
10:45:36 14 inflammatory disorders, and the disorders that we'll  
10:45:39 15 be talking about today, including Parkinson's and  
10:45:41 16 dementias.

10:45:43 17 I then went on to specialize in  
10:45:45 18 those disorders specifically. So I did a two-year  
10:45:48 19 fellowship in behavioral neurology at the Harvard  
10:45:53 20 Beth Israel Program, and then after that was hired  
10:45:54 21 as an assistant professor of neurology at  
10:46:00 22 Vanderbilt. So I've been in that role for about  
10:46:02 23 four and a half years now.

10:46:04 24 At Vanderbilt, I am the director of  
10:46:06 25 the Frontotemporal Dementia Clinic, also a faculty

10:46:11 1 member in the Memory and Alzheimer's Center in the  
10:46:14 2 Bioethics Department and the Vanderbilt Brain  
10:46:17 3 Institute.

10:46:17 4 Q. So that's your educational credentials, but  
10:46:22 5 what do you actually do at Vanderbilt?

10:46:23 6 A. I do a number of different things. So I see  
10:46:26 7 patients clinically. So I evaluate patients with  
10:46:29 8 clinically presenting memory problems, cognitive  
10:46:32 9 disorders. I also do research.

10:46:35 10 So my research focuses on  
10:46:38 11 understanding the relationship between brain damage,  
10:46:41 12 so neurological diseases and behavior, so whatever  
10:46:45 13 symptoms the patient has. And I focus on using  
10:46:48 14 different types of MRI scans to do that research. I  
10:46:53 15 also do research in dementia patients where I  
10:46:56 16 evaluate them longitudinally to see how their  
10:46:59 17 diseases progress and change over time.

10:47:02 18 I'm involved in teaching at the  
10:47:03 19 medical center, so that involves clinical teaching.  
10:47:05 20 I'll have medical students, residents, and fellows  
10:47:08 21 who will rotate through -- with me in clinic where  
10:47:11 22 we'll see patients together and discuss the  
10:47:13 23 different diagnoses and tests.

10:47:15 24 It also includes teaching in the  
10:47:18 25 research setting where I'll have undergraduate

10:47:21 1 students, graduate students, post-doctoral students  
10:47:24 2 interested in neuroimaging research, and then giving  
10:47:27 3 lectures to kind of students, but also to other  
10:47:31 4 neurologists who don't have the same training and  
10:47:33 5 background in cognitive disorders.

10:47:36 6 Q. Do you do any -- well, let me ask it this way.  
10:47:40 7 Would you describe yourself as a professional  
10:47:45 8 testifier?

10:47:46 9 A. No, I've testified once before, but I do some  
10:47:50 10 forensic work. So about ten percent of my time is  
10:47:53 11 spent doing forensic cases.

10:47:55 12 Q. Now, just generally, what's the focus of your  
10:47:58 13 clinical work? Can you talk about the types of  
10:48:00 14 diseases that you see in your clinical practice?

10:48:02 15 A. Yeah, and so my clinical practice focuses on  
10:48:05 16 patients with cognitive disorders. So by far, the  
10:48:08 17 most common reason and the most common thing I'm  
10:48:11 18 evaluating for is dementia, mild cognitive  
10:48:15 19 impairment, and determining the different types of  
10:48:17 20 dementia that may be present.

10:48:18 21 Q. And have you -- are you active in any  
10:48:24 22 professional organizations in your field?

10:48:25 23 A. I am. So I'm a member of a number of  
10:48:28 24 professional groups, including the American Academy  
10:48:32 25 of Neurology, American Neurological Association,

10:48:35 1 Alzheimer's Associations, and the American  
10:48:38 2 Neuropsychiatric Association.

10:48:40 3 Q. Have you received honors or awards for your  
10:48:43 4 work?

10:48:43 5 A. I have. So I have received awards from the  
10:48:45 6 American Academy of Neurology, the American  
10:48:48 7 Neuropsychiatric Association, and the Alzheimer's  
10:48:51 8 Disease for some of my work in behavioral neurology.

10:48:55 9 MR. MAGNANI: Your Honor, at this time  
10:48:56 10 move to qualify Dr. Ryan Darby as an expert in  
10:49:01 11 diagnosing and treating cognitive and behavioral  
10:49:04 12 dementias.

10:49:04 13 THE COURT: Any objection?

10:49:06 14 MR. LOONAM: No. I don't know if  
10:49:07 15 that'll be necessary for the experts going forward,  
10:49:08 16 but, yes.

10:49:09 17 THE COURT: Okay. Then he is so  
10:49:11 18 qualified.

10:49:12 19 MR. MAGNANI:

10:49:12 20 Q. So Dr. Darby, let me ask you, do you --  
10:49:18 21 qualified as an expert in this case -- are you  
10:49:20 22 expert on competency-related law?

10:49:22 23 A. No, so that's not something that I have  
10:49:24 24 expertise in. And so, I will counsel patients about  
10:49:28 25 things like driving, financial decision-making, but

10:49:31 1 I don't have expertise in competency to stand trial.

10:49:34 2 Q. What about specific legal burdens of proof?

10:49:38 3 A. No, that's not something that I have background  
10:49:40 4 or expertise in.

10:49:42 5 Q. Did you write expert reports in this case?

10:49:44 6 A. I did.

10:49:47 7 MR. MAGNANI: Your Honor, I do believe  
10:49:48 8 these have been pre-admitted, but I'll note for the  
10:49:51 9 record -- would you like the witness to identify his  
10:49:54 10 reports?

10:49:55 11 THE COURT: They've already been  
10:49:57 12 pre-admitted. I don't need to have them identified.

10:50:00 13 MR. MAGNANI: Very well. I'll note for  
10:50:01 14 the record these are Exhibits 38 and 39.

10:50:04 15 Q. Before we proceed, did you prepare a PowerPoint  
10:50:09 16 presentation for your testimony today?

10:50:11 17 A. I did. It's something that I typically find to  
10:50:13 18 be helpful when I'm discussing these types of  
10:50:17 19 issues.

10:50:19 20 MR. MAGNANI: And, Your Honor --

10:50:22 21 Q. Before this morning, was the PowerPoint  
10:50:25 22 presentation something you created entirely on your  
10:50:28 23 own?

10:50:29 24 A. Yes, it is something that I created using some  
10:50:32 25 of the references that were discussed earlier.

10:50:34 1 MR. MAGNANI: And, Your Honor, I'd like  
10:50:36 2 to put on this PowerPoint presentation. I'm only  
10:50:39 3 flagging that I made the redactions that Your Honor  
10:50:41 4 requested this morning.

10:50:42 5 THE COURT: Okay. I'm going to allow  
10:50:43 6 it as demonstrative evidence -- or demonstrative  
10:50:47 7 exhibits, rather.

10:50:48 8 MR. MAGNANI: Very well. Does Your  
10:50:50 9 Honor mind if I give the witness the clicker to  
10:50:53 10 advance slides?

10:50:53 11 THE COURT: Sure. Not a problem.

10:51:11 12 MR. MAGNANI:

10:51:11 13 Q. Okay. Dr. Darby, so as an expert in diagnosing  
10:51:14 14 and treating behavioral and cognitive dementias, can  
10:51:17 15 you share with the Court your top-line conclusions,  
10:51:22 16 expert opinions in this case?

10:51:23 17 A. So I have three main opinions in this case. So  
10:51:27 18 the first opinion is regarding Mr. Brockman's  
10:51:30 19 diagnosis. So I believe that Mr. Brockman has a  
10:51:33 20 diagnosis of Parkinson's disease.

10:51:36 21 I think it is also possible that he  
10:51:38 22 has a diagnosis of Alzheimer's disease. So the  
10:51:43 23 second main conclusion I have is regarding the  
10:51:45 24 severity of the cognitive problems that Mr. Brockman  
10:51:48 25 has.

10:51:50 1 And so, I think he is at the stage  
10:51:52 2 of mild cognitive impairment. I think it is  
10:51:56 3 possible he could have progressed to the stage of  
10:51:58 4 mild dementia, but he does not have moderate or  
10:52:01 5 severe dementia.

10:52:07 6 MR. LOONAM: Objection. This is not in  
10:52:09 7 his expert report, Your Honor. This is different  
10:52:10 8 from his expert report.

10:52:12 9 THE COURT: Okay.

10:52:16 10 MR. LOONAM: His expert report did not  
10:52:17 11 exclude moderate dementia, and we can go through the  
10:52:20 12 expert report, but I object to his testimony as  
10:52:23 13 beyond the scope of his expert testimony disclosed  
10:52:25 14 to us.

10:52:25 15 THE COURT: Well, I'm going to hear the  
10:52:27 16 testimony, and then you can raise it on  
10:52:28 17 cross-examination. If you are correct, then I'll  
10:52:31 18 strike the testimony, and since we don't have a  
10:52:34 19 jury.

10:52:34 20 MR. LOONAM: Thank you, Your Honor.

10:52:35 21 MR. MAGNANI: Although we don't have a  
10:52:37 22 jury, to the point he's impugning the witness, I do  
10:52:40 23 have quotes from the report that support what he's  
10:52:43 24 saying, and I am prepared to read them if the Court  
10:52:45 25 would like to hear.

10:52:46 1 No need?

10:52:47 2 THE COURT: Continue.

10:52:48 3 MR. MAGNANI: Okay.

10:52:49 4 Q. Sorry, Dr. Darby, could you just repeat that  
10:52:53 5 second opinion again?

10:52:54 6 A. Yes. So my second opinion is regarding the  
10:52:57 7 severity of his cognitive problems. And so, I think  
10:53:00 8 that he is likely in the stage of mild cognitive  
10:53:02 9 impairment. I think it is possible that he could  
10:53:06 10 have progressed into the mild dementia stage, but I  
10:53:09 11 think that he is not in the moderate or severe  
10:53:12 12 dementia stage.

10:53:14 13 Q. What's your third opinion, Dr. Darby?

10:53:17 14 A. The third opinion is regarding the certainty of  
10:53:23 15 that, and that is impaired by the fact that he's  
10:53:24 16 been exaggerating. And I state that because there  
10:53:28 17 have been examples where he clearly has been  
10:53:30 18 performing at a higher level than his cognitive  
10:53:33 19 testing and reports indicate.

10:53:37 20 I also base that on the objective  
10:53:39 21 neuroimaging data that shows that he is at a milder  
10:53:42 22 stage than he is presenting with clinically.

10:53:49 23 Q. I'd like to just take these sort of one at a  
10:53:51 24 time, and talk about how you get to those  
10:53:54 25 conclusions, but I guess before I do let me ask. Do

10:53:56 1 you have an opinion on the Defendant's competence?

10:54:00 2 **A.** And so, regarding my -- his competence, I

10:54:04 3 don't. So I don't have a clear sense of what his

10:54:07 4 actual level of cognitive impairment is, so I can't

10:54:10 5 make that determination.

10:54:11 6 **Q.** Do you feel like you have an accurate sense to

10:54:14 7 understand, based on your experience, the type of

10:54:17 8 assistance that an accused defendant has to provide

10:54:20 9 to counsel?

10:54:20 10 **A.** No, I have a general understanding of that, but

10:54:23 11 not a specific understanding.

10:54:25 12 **Q.** So who hired you, Dr. Darby?

10:54:27 13 **A.** So I was hired by the Department of Justice

10:54:30 14 prosecution team.

10:54:31 15 **Q.** Did you work with the prosecution team in this

10:54:33 16 case?

10:54:33 17 **A.** I did, yes.

10:54:34 18 **Q.** How did you work with them?

10:54:36 19 **A.** So I reviewed documents that were made

10:54:38 20 available to me. I recommended certain tests that

10:54:42 21 would be helpful, and help in coordinating those

10:54:46 22 tests and interpreting them. I communicated

10:54:48 23 findings.

10:54:50 24 I collaborated with other experts

10:54:52 25 involved in the case. I wrote reports for the case,

10:54:56 1 and I prepared for this testimony.

10:54:58 2 Q. Did you ever work with Defense counsel in this  
10:55:01 3 case?

10:55:02 4 A. No, not directly. Um, there may have been some  
10:55:05 5 e-mail exchanges involved in coordinating some of  
10:55:09 6 the tests with Prosecution and Defense, but I did  
10:55:12 7 not work directly with them.

10:55:13 8 Q. What about the Court? Did you work with any  
10:55:16 9 members of the judicial branch in this case?

10:55:18 10 A. Not to my knowledge, no.

10:55:19 11 Q. Are you being paid for your work in this case?

10:55:22 12 A. I am. So I'm paid \$350 an hour for my work.

10:55:26 13 Q. And do you know, approximately, how much you've  
10:55:29 14 been paid for your work in this case?

10:55:33 15 A. I think a rough estimate is around \$80,000.

10:55:36 16 Q. So a lot of hours?

10:55:38 17 A. Yes, a lot of hours.

10:55:39 18 Q. What did you do during all of those hours?

10:55:41 19 A. Well, a lot of it was review of documents. And  
10:55:44 20 so, reviewing the evidence that was available in  
10:55:48 21 this case. Um, it also included reviewing and  
10:55:52 22 organizing the diagnostic tests, so the tests that  
10:55:55 23 we recommended ordering, and interpreting those.

10:55:58 24 It involved an interview, and  
10:56:02 25 evaluation, and examination with Mr. Brockman that

10:56:04 1 happened in May of 2021. I also interviewed his  
10:56:07 2 wife, Dorothy, at that time with her attorney  
10:56:10 3 present. Um, it involved discussions with the other  
10:56:13 4 experts about the evidence that they had obtained.

10:56:16 5 It involved the writing of the  
10:56:18 6 reports, and then the preparation of this testimony.

10:56:22 7 Q. Did you do this work in isolation?

10:56:24 8 A. No, I was part of a team of other expert  
10:56:27 9 witnesses that were involved in this case.

10:56:29 10 Q. How did -- well how did this team, as you  
10:56:33 11 described it, work together?

10:56:35 12 A. And so, you know, my background and experience  
10:56:38 13 is in neurology. So I -- specifically behavioral  
10:56:44 14 neurology, so I was focused on the medical  
10:56:46 15 diagnosis, the testing that would be appropriate and  
10:56:49 16 helpful in this case, and the knowledge of the  
10:56:52 17 diseases and their time course and severity.

10:56:54 18 Dr. Park Dietz was also involved in  
10:56:57 19 the case. So he is a forensic psychiatrist who has  
10:57:01 20 experience and expertise in medical legal  
10:57:04 21 determinations, like competency to stand trial.  
10:57:07 22 Dr. Robert Denney was an expert neuropsychologist in  
10:57:11 23 this case. So Dr. Denney has experience  
10:57:14 24 administering and interpreting the  
10:57:17 25 neuropsychological tests, both in dementia patients

10:57:20 1 and evaluations of competency.

10:57:22 2 Then I also consulted with  
10:57:24 3 Dr. Maria Ponisio. So Dr. Ponisio is a nuclear  
10:57:28 4 radiologist. She assisted in evaluating the PET  
10:57:32 5 scans, as well as doing quantitative analysis on  
10:57:35 6 those PET scans.

10:57:36 7 Q. So is it fair to say that the team worked  
10:57:39 8 collaboratively with each person bringing their  
10:57:42 9 respective expertise?

10:57:44 10 A. We did, yes. We discussed at the beginning the  
10:57:47 11 benefits and cons of working together, versus  
10:57:49 12 entirely independently. The thought was that by  
10:57:53 13 sharing opinions and information that would lead  
10:57:55 14 each of us to arrive at the most accurate  
10:57:59 15 determination.

10:57:59 16 Q. I want to explore the limits of this  
10:58:02 17 collaboration. Did you read each others' reports  
10:58:05 18 before they were filed?

10:58:05 19 A. No, I did not read any of the other reports  
10:58:08 20 before they were filed.

10:58:09 21 Q. Did you share your report or drafts of your  
10:58:11 22 report with any member of the prosecution team  
10:58:14 23 before it was filed?

10:58:16 24 A. I did not.

10:58:17 25 Q. So I want to start with your first conclusion,

10:58:20 1 Doctor. Well, why don't you just tell us what is  
10:58:23 2 Parkinson's disease?

10:58:24 3 **A.** Yeah, so Parkinson's disease is a motor  
10:58:28 4 disorder of the brain. And so, it is a  
10:58:31 5 neurodegenerative disorder, so something that  
10:58:34 6 progresses over time that affects movement.

10:58:36 7 So when we see patients with  
10:58:38 8 Parkinson's, they have the typical findings of  
10:58:40 9 slowness with their movements, slower to initiate  
10:58:43 10 those. They can have a tremor that occurs at rest.  
10:58:46 11 They can have stiffness when we try and move them.

10:58:49 12 That can lead to findings that we  
10:58:51 13 see when patients are walking where they have a  
10:58:53 14 characteristic gait. It can lead to decreased  
10:58:58 15 expression in facial expressions.

10:59:00 16 Parkinson's disease can also be  
10:59:01 17 associated with non-motor symptoms. In some cases,  
10:59:04 18 there are sleep problems or cognitive issues, or  
10:59:08 19 affection on the autonomic nervous system.

10:59:11 20 **Q.** Just to -- why do you think that Mr. Brockman  
10:59:14 21 has Parkinson's disease?

10:59:16 22 **A.** Well, I think there's a number of pieces of  
10:59:19 23 evidence that really support that. Looking at  
10:59:22 24 videos of him giving speeches, in 2018 it appears  
10:59:26 25 he's having early signs of that that are more clear

10:59:29 1 by 2019 in those videos.

10:59:31 2 He also had evaluations by medical  
10:59:33 3 neurologists with expertise in Parkinson's disease,  
10:59:36 4 beginning with Dr. Jankovic in -- in January of  
10:59:41 5 2019, that diagnosed him with Parkinson's. When I  
10:59:45 6 evaluated him in May, my examination was also  
10:59:47 7 consistent with that.

10:59:48 8 And he also had a special type of  
10:59:51 9 brain imaging scan called a DaTscan. And so this  
10:59:57 10 looks at the dopamine neurons in the brain. In  
10:59:58 11 Parkinson's disease, one of the things that happens  
11:00:00 12 is those dopamine neurons are damaged. His scan  
11:00:03 13 showed evidence there was damage to those dopamine  
11:00:06 14 neurons. So all of those things support diagnosis  
11:00:09 15 of Parkinson's.

11:00:11 16 Q. If you know, to what extent did the other  
11:00:14 17 experts in this case agree with that opinion?

11:00:15 18 A. I think essentially everything agrees with the  
11:00:18 19 diagnosis of Parkinson's, both his treating  
11:00:20 20 physicians and the other experts in this case.

11:00:22 21 Q. Doctor, what's dementia with Lewy bodies or  
11:00:25 22 Lewy bodies dementia?

11:00:27 23 A. So Lewy bodies dementia is caused by the same  
11:00:31 24 biological change as Parkinson's disease. So it's  
11:00:34 25 the same underlying protein that accumulates, but it

11:00:37 1 affects different areas of the brain, and that leads  
11:00:39 2 to different symptoms.

11:00:40 3 So in addition to Parkinson's motor  
11:00:43 4 symptoms, the things that we look for in Lewy body  
11:00:48 5 disease are visual hallucinations. These are  
11:00:51 6 recurrent. They happen over and over, and they're  
11:00:53 7 well formed, so often fully-formed figures, persons,  
11:00:57 8 faces.

11:00:58 9 The second thing that we look for  
11:01:02 10 is REM sleep behavior disorder. And so, this is  
11:01:05 11 when a patient will actually acts out their dreams  
11:01:08 12 while they're asleep.

11:01:11 13 Q. Did you consider this as a potential diagnosis?

11:01:15 14 A. I did. Before moving on, I just wanted to say  
11:01:18 15 the last thing associated with dementia with Lewy  
11:01:22 16 bodies is fluctuations, so changes of arousal or  
11:01:25 17 attention such that the patient may not respond.

11:01:29 18 This was considered as a diagnosis  
11:01:30 19 early on. It was a diagnosis that his treating  
11:01:34 20 clinicians at Baylor raised as a concern. It was  
11:01:37 21 also one of the diagnoses that was initially raised  
11:01:40 22 by the Defense in their motion for competency.

11:01:43 23 Q. Were you able to determine from your record  
11:01:45 24 review why they suspected this diagnosis?

11:01:48 25 A. I think it was largely based on the fact that

11:01:50 1 he had Parkinson's. So because Parkinson's and Lewy  
11:01:54 2 bodies can be caused by the same protein, that was  
11:01:56 3 initially a concern. It was also the fact that  
11:01:59 4 Mr. Brockman stated in his neuropsychological  
11:02:02 5 testing that he had seen a bug moving on a table  
11:02:05 6 that was interpreted as a hallucination.

11:02:08 7 And because Mr. Brockman had  
11:02:10 8 reported movements in his sleep that happened  
11:02:14 9 previously where it raised a concern that could have  
11:02:16 10 been dream reenactment consistent with REM sleep  
11:02:21 11 behavior disorder.

11:02:21 12 Q. You mentioned this was early, clinical  
11:02:24 13 diagnosis. But again, to the extent you know is  
11:02:28 14 this a diagnosis any of the experts in this case are  
11:02:32 15 advocating for today?

11:02:34 16 A. No, I don't believe so. So I don't think any  
11:02:37 17 of the other experts have mentioned this as a  
11:02:39 18 diagnosis, although they have mentioned a related  
11:02:42 19 disease, Parkinson's disease dementia.

11:02:45 20 Q. What's -- you said they're related. What's the  
11:02:47 21 relation?

11:02:48 22 A. And so, really the issue is timing. In Lewy  
11:02:52 23 bodies disease, the features that I mentioned and  
11:02:55 24 the cognitive happen early. It happens within the  
11:02:59 25 first year of someone having the motor symptoms of

11:03:03 1 Parkinson's disease.

11:03:03 2 But we know that if we follow  
11:03:04 3 patients with Parkinson's disease five or ten years  
11:03:07 4 into their disease course, they may also develop  
11:03:10 5 hallucinations, and some of these other features  
11:03:13 6 that really resemble Lewy bodies dementia. And  
11:03:16 7 that's just because the disease is spreading into a  
11:03:19 8 different part of the brain and causing those  
11:03:20 9 symptoms.

11:03:22 10 Q. Doctor, you said Mr. Brockman might also have  
11:03:25 11 Alzheimer's disease. Why do you think that?

11:03:26 12 A. So that was based on a number of things in this  
11:03:30 13 case. The first is the amyloid PET scan that he  
11:03:33 14 had. So just as a bit of background, there are a  
11:03:36 15 number of different proteins that are involved in  
11:03:38 16 Alzheimer's disease. The first one is amyloid.

11:03:41 17 So that is the first thing that we  
11:03:42 18 think happens in this disease process, but that  
11:03:47 19 happens many years before someone develops symptoms.  
11:03:50 20 It can happen a decade before someone has developed  
11:03:53 21 any of the other changes or the clinical problems  
11:03:55 22 associated with that.

11:03:56 23 And so, there's another protein  
11:03:59 24 that is deposited later in the brain and becomes  
11:04:02 25 abnormal called tau. It's thought that that tau

11:04:07 1 protein eventually causes brain damage, and so there  
11:04:11 2 is neurodegeneration or brain damage. It's the  
11:04:14 3 brain damage that causes the clinical symptoms.

11:04:17 4 And so, in Alzheimer's disease, you  
11:04:20 5 know before the advent of these types of specialized  
11:04:22 6 tests, we didn't have a way of saying there was  
11:04:24 7 amyloid in the brain. But the PET scan is actually  
11:04:27 8 able to bind to that through a tracer, and we can  
11:04:31 9 visualize and see whether or not there is amyloid in  
11:04:33 10 the brain.

11:04:34 11 Mr. Brockman had a positive amyloid  
11:04:36 12 scan, which indicates he has that first step. The  
11:04:40 13 other thing we consider were the locations of brain  
11:04:43 14 damage that were evident on his FDG-PET. And so,  
11:04:47 15 the FDG-PET is a different type of PET scan. It's  
11:04:50 16 looking at brain energy or metabolism. And that  
11:04:54 17 tells us how active a certain area of the brain is.

11:04:59 18 And so if there's a reduction  
11:05:00 19 there, we think that indicates there's brain damage  
11:05:02 20 in that location. We look for where those locations  
11:05:06 21 are to see if it fits the pattern of locations we  
11:05:09 22 could see in Alzheimer's disease.

11:05:11 23 Q. And, Doctor, can you just do your best to  
11:05:13 24 describe the rate of amyloid -- excuse me --  
11:05:20 25 accumulation and how long it accumulates before it

11:05:22 1 gets to the maximum level?

11:05:25 2 **A.** Yes, so that accumulation happens over the  
11:05:28 3 course of years or even a decade. Now that amyloid  
11:05:32 4 deposition is happening and increasing, and reaches  
11:05:35 5 its peak even while a patient is in the normal  
11:05:38 6 stage, so without any cognitive impairment. It's  
11:05:40 7 essentially at the highest level.

11:05:42 8 And then as a patient progresses  
11:05:44 9 from normal to mild cognitive impairment to  
11:05:47 10 dementia, there's really not a corresponding change  
11:05:50 11 in the amyloid. So the amyloid level stays the  
11:05:53 12 same. If you see a positive amyloid scan, it  
11:05:57 13 doesn't necessarily tell you the degree of cognitive  
11:05:59 14 problems someone would be having.

11:06:01 15 It's an indicator that disease and  
11:06:05 16 that marker is there, which is necessary part for  
11:06:08 17 Alzheimer's to occur, but isn't sufficient. The  
11:06:10 18 other changes, the tau, the brain damage -- those  
11:06:13 19 are necessary to get to the clinical symptoms.

11:06:15 20 **Q.** So if a person had positive amyloid without any  
11:06:20 21 symptoms, what does amyloid tell us?

11:06:23 22 **A.** Well, it tells you that those symptoms are more  
11:06:25 23 likely related to Alzheimer's disease. So again,  
11:06:28 24 it's that first biological change that you see. Um,  
11:06:31 25 and so you try and correspond that to the clinical

11:06:37 1 symptoms and brain damage to see if that's more  
11:06:39 2 likely than not.

11:06:39 3 Q. Are you able to estimate just about how common  
11:06:44 4 positive amyloid factor is in people of  
11:06:47 5 Mr. Brockman's age?

11:06:49 6 A. So amyloid and the disease process, as in  
11:06:52 7 Alzheimer's disease, increase over time. And so, in  
11:06:55 8 someone who is in their 80's, there may be as many  
11:06:58 9 as 25 or even 30 or 40 percent of people who would  
11:07:02 10 have a positive amyloid PET scan. The Alzheimer's  
11:07:05 11 disease just becomes much, much more common.

11:07:07 12 And so, it is certainly possible  
11:07:09 13 that someone could have normal cognition and have a  
11:07:12 14 positive amyloid scan.

11:07:14 15 Q. Dr. Darby, can you -- I'm going to ask you to  
11:07:20 16 advance two slides, please. Sorry, I'll let you  
11:07:23 17 drive, but I just want to -- okay. Can you please  
11:07:25 18 just summarize the similarities and differences  
11:07:27 19 between the diseases that you have just described  
11:07:30 20 for us?

11:07:30 21 A. Yeah, so this is a chart just describing the  
11:07:35 22 differences that we see in between these. And in  
11:07:37 23 each one of these neurodegenerative disorders, we  
11:07:40 24 see the disease start with the biological changes.  
11:07:43 25 So what are the abnormal proteins that we see?

1 And then, those changes eventually  
2 result in brain damage to specific locations. It's  
3 that brain damage, as it becomes significant enough,  
4 that leads to the clinical symptoms. So in  
5 something like Parkinson's disease and Lewy bodies  
6 disease, we actually had that same abnormal protein,  
7 that same biological process, but it affects  
8 different parts of the brain. That's what leads to  
9 the differences in the symptoms that we see.

10 In the case of Alzheimer's disease,  
11 we have the two proteins that we were discussing.  
12 So the amyloid protein, which is that first change,  
13 and then the tau protein, which is the second  
14 change. And it's really as the tau protein  
15 progresses and causes brain damage in memory areas  
16 that the typical findings of memory impairment  
17 occur.

18 Q. Dr. -- Dr. Darby, you just sort of explained  
19 the basis of your first opinion related to disease.  
20 I'd like to ask you now about your second opinion.

21 A. Yes, so my second opinion was regarding the  
22 severity of the cognitive problems. And so, my  
23 opinion was that Mr. Brockman was at the stage of  
24 mild cognitive impairment. It's possible he could  
25 have progressed into the mild dementia stage, but

11:08:59 1 that he isn't in the moderate or severe dementia  
11:09:03 2 stage.

11:09:03 3 Q. And can you define these terms? You are  
11:09:07 4 talking mild cognitive impairment, dementia -- can  
11:09:08 5 you please define these terms?

11:09:10 6 A. Sure. So I have another slide that goes  
11:09:13 7 through some of the different stages. These are  
11:09:15 8 really terms that we're using to describe the  
11:09:17 9 severity of the cognitive impairment. So it's the  
11:09:21 10 level of cognitive impairment. And the  
11:09:24 11 differentiation point is whether that is severe  
11:09:26 12 enough to impact Defendant's ability to function  
11:09:32 13 independently.

11:09:32 14 So if we have reports of cognitive  
11:09:34 15 dysfunction prior to the loss of independence, we  
11:09:36 16 would call that mild cognitive impairment or an MCI.  
11:09:39 17 And examples of problems that a patient with MCI  
11:09:43 18 might have might be memory lapses, so losing track  
11:09:48 19 of names, appointments, or conversations. Being  
11:09:51 20 slower to complete tasks. It's harder to make  
11:09:53 21 decisions, but even with challenges being able to do  
11:09:57 22 these things independently.

11:09:58 23 When a patient reaches a stage of  
11:10:00 24 mild dementia, there is the loss of some of this  
11:10:03 25 functional independence. So complex activities like

11:10:07 1 being able to work may be challenging. Financial  
11:10:10 2 decision-making may be challenging, and there may be  
11:10:13 3 more difficulty in organizing thoughts.

11:10:16 4 By the time someone is in the  
11:10:18 5 moderate stage of dementia, they really need more  
11:10:20 6 assistance. And so, this is a case where in the  
11:10:22 7 moderate stage, you wouldn't feel comfortable with a  
11:10:26 8 patient being left alone for long period of time.  
11:10:28 9 They may be disoriented and lose track of where they  
11:10:32 10 are, having difficulty recognizing friends, and may  
11:10:35 11 lose memory of certain aspects of personal  
11:10:37 12 information like their telephone number or address.

11:10:42 13 Q. You are describing dementia?

11:10:43 14 A. Yeah.

11:10:44 15 Q. What causes dementia?

11:10:46 16 A. Dementia is caused by a number of different  
11:10:50 17 diseases. It's an umbrella term. And so,  
11:10:52 18 Alzheimer's disease, Lewy bodies, Parkinson's --  
11:10:54 19 those are all causes of neurodegenerative disorders  
11:10:57 20 which progress over time to get to these stages, but  
11:11:00 21 one could have a more acute change like a stroke or  
11:11:02 22 brain trauma that would cause a similar result.

11:11:05 23 Q. So if it could be caused -- I mean, do we care  
11:11:11 24 -- does it matter what causes the dementia?

11:11:13 25 A. Well, for determining the level of the

11:11:16 1 severity, no. So the cause doesn't contribute to  
11:11:19 2 that level of severity. Um, but in thinking about  
11:11:22 3 the time course it does. And so, you know, diseases  
11:11:25 4 like Alzheimer's and Parkinson's progress over time.  
11:11:28 5 Other things like an acute brain trauma wouldn't be  
11:11:30 6 expected to progress over time.

11:11:32 7 Q. So in coming to a forensic opinion, would it be  
11:11:38 8 relevant whether a person got dementia in 2017  
11:11:42 9 versus 2021?

11:11:43 10 A. It would. And so, again we know that this  
11:11:49 11 diseases progress. As a ballpark figure, someone  
11:11:52 12 who is diagnosed at the early mild dementia stage,  
11:11:56 13 it may be five or ten years as that progresses  
11:12:00 14 towards death. And so, if someone was diagnosed  
11:12:01 15 with dementia in 2017 for instance, we would expect  
11:12:04 16 that progression to have occurred, and for them to  
11:12:07 17 be at a very advanced stage now.

11:12:09 18 But someone who is diagnosed more  
11:12:11 19 recently in that stage, you know, with only a year  
11:12:13 20 to progress or smaller amount of time, we wouldn't  
11:12:16 21 expect that severe progression to happen.

11:12:19 22 Q. Dr. Darby, in your clinical practice, how do  
11:12:22 23 you diagnose your patients on this dementia severity  
11:12:28 24 scale you just described?

11:12:30 25 A. It starts with an interview with the patient

11:12:32 1 and their family. This is where I see a patient in  
11:12:35 2 clinic and ask them about their concerns about the  
11:12:38 3 memory problems. I would ask for examples of that.

11:12:40 4 I would interview a family member,  
11:12:42 5 someone close to the patient to know about the  
11:12:44 6 observations that they're noting as well. I would  
11:12:48 7 do an examination. So I would do a neurological  
11:12:50 8 examination, and do cognitive testing, both myself  
11:12:54 9 with a bedside form of cognitive testing, as well as  
11:12:58 10 referring to a patient to a neuropsychologist to do  
11:13:00 11 more thorough testing.

11:13:02 12 Then I get brain imaging to see if  
11:13:05 13 there's evidence of brain damage that would go along  
11:13:08 14 with these diseases that we're concerned about.

11:13:11 15 Q. And so, is that fair to say in your clinical  
11:13:14 16 practice your sources of information are images or  
11:13:17 17 just what comes from the patient?

11:13:18 18 A. Exactly, yes.

11:13:21 19 Q. If you take Mr. Brockman's presentation at face  
11:13:24 20 value, where would you diagnose him on this scale?

11:13:29 21 A. So based on the reports that he's giving  
11:13:32 22 currently, he would be at the stage of moderate to  
11:13:34 23 severe dementia. So he is reporting, and his family  
11:13:39 24 is reporting, that he cannot use a knife, that he  
11:13:42 25 has difficulty -- at times -- recognizing his

11:13:44 1 grandson, that he gets confused as to where he is,  
11:13:48 2 that he has confusion while putting clothes on, and  
11:13:51 3 may put his pants on his arms or vice versa. And  
11:13:55 4 so, these are all examples of a patient that would  
11:13:57 5 be at an advanced stage of dementia.

11:14:02 6 Q. If you saw him in your normal, clinical  
11:14:05 7 practice, might you have diagnosed him that way?

11:14:07 8 A. Yes, if -- you know, if these were the symptoms  
11:14:11 9 a patient was reporting to me, you know, those would  
11:14:13 10 be consistent with moderate or severe dementia  
11:14:16 11 stage.

11:14:16 12 Q. So why do you think that he is in the mild  
11:14:21 13 cognitive impairment to potentially mild dementia  
11:14:23 14 range?

11:14:23 15 A. Well, I think in this case in the forensic role  
11:14:27 16 I examined the evidence more critically than I would  
11:14:30 17 have, so I had a lot more information to base that  
11:14:33 18 opinion on. And so, for instance I had videos of  
11:14:38 19 him giving depositions or speeches, and can compare  
11:14:42 20 those to the way he was reporting the symptoms and  
11:14:45 21 the cognitive testing results and see that there  
11:14:47 22 were discrepancies.

11:14:49 23 I had his work performance, so his  
11:14:53 24 ability to continue working and even deposition  
11:14:55 25 testimony from some of his work associates who were

11:14:59 1 able to comment on his cognitive abilities in the  
11:15:02 2 work setting.

11:15:03 3 And then, I had the interview with  
11:15:06 4 him himself. So when I saw him in May, and the  
11:15:10 5 comparison of those interview findings with his  
11:15:14 6 cognitive testing and reporting. And then the  
11:15:17 7 imaging itself to compare.

11:15:19 8 Q. Okay. So you gave some examples of  
11:15:25 9 demonstration of higher-cognitive function. So I'm  
11:15:28 10 just wondering besides those, what else makes you  
11:15:31 11 think he has just mild cognitive impairment or mild  
11:15:35 12 cognitive impairment dementia?

11:15:36 13 A. Yeah, well I think the other things -- one is  
11:15:39 14 the neuroimaging. So we have the neuro as objective  
11:15:47 15 demonstration of the brain severity we're seeing,  
11:15:50 16 and correspondences more closely to the symptoms we  
11:15:53 17 expect to see. We also have the expected disease  
11:15:55 18 course, so how should this progress over time?

11:15:58 19 My evaluation of him in May he was  
11:16:01 20 at the mild cognitive impairment stage. And so we  
11:16:03 21 have a sense of how that should progress, absent  
11:16:07 22 extenuating circumstances.

11:16:08 23 Q. So let's start with the imaging. What -- just  
11:16:12 24 generally, what does neuroradiological imaging show?

11:16:18 25 A. And so, in this case I think the important

11:16:20 1 things that we're looking for in the neuroimaging  
11:16:23 2 are evidence for brain damage. So the evidence for  
11:16:26 3 brain damage, how severe it is, and what parts of  
11:16:29 4 the brain it's happening in.

11:16:30 5           There are two ways that we can look  
11:16:32 6 at that. One is using the FDG-PET. And so, this is  
11:16:37 7 a PET scan that looks at brain metabolism or brain  
11:16:42 8 function. So it's actually binding to sugar in the  
11:16:45 9 blood, which is the body's source of energy. So it  
11:16:49 10 looks at where that sugar is going in the brain. If  
11:16:52 11 there's less sugar going to certain parts of the  
11:16:55 12 brain, that indicates that there could be underlying  
11:16:58 13 damage to that area.

11:17:00 14           The other tests that we can use is  
11:17:02 15 the brain MRI scan. So the brain MRI looks at the  
11:17:07 16 brain's size or the brain volume. And so, we can  
11:17:10 17 get a sense of that brain volume and compare that to  
11:17:14 18 what we would expect normal -- cognitively normal  
11:17:18 19 80-year-old to have to get a sense of -- again if  
11:17:21 20 there's a lower brain volume, that can indicate  
11:17:23 21 there's been brain damage.

11:17:24 22 **Q.** Of the two tests that you just mentioned, the  
11:17:27 23 FDG-PET and the MRI, which one is more, informative  
11:17:35 24 of a patient's neurodegeneration?

11:17:37 25 **A.** So the FDG-PET tends to be more sensitive. So

11:17:40 1 we can see changes on the FDG-PET earlier than we  
11:17:44 2 can appreciate them on the MRI scan.

11:17:47 3 Q. And so, if you can measure metabolic uptake or  
11:17:55 4 just brain activity in the brain, why can't you  
11:17:58 5 entirely base your diagnosis off an FDG-PET?

11:18:02 6 A. Yeah, so dementia can't be diagnosed just by  
11:18:05 7 the imaging. And the reason for that is although  
11:18:08 8 there's a strong correlation between the amount of  
11:18:12 9 brain damage in a patient's clinical symptoms, it's  
11:18:15 10 not one-to-one. So the same amount of damage in two  
11:18:18 11 different patients could lead to very different  
11:18:21 12 levels of cognitive impairment, because they're  
11:18:24 13 starting from different points.

11:18:25 14 And so, in a patient who has a high  
11:18:28 15 level of intelligence, they're able to compensate  
11:18:31 16 for the same amount of brain damage, more than a  
11:18:34 17 person that would not have that level of  
11:18:36 18 intelligence. So it's really the rest of the brain  
11:18:39 19 being able to compensate for that, that can change  
11:18:41 20 that. So it's a correlation, but not a one-to-one  
11:18:44 21 association.

11:18:45 22 Q. So do you -- is that sometimes referred to as a  
11:18:47 23 patient's baseline?

11:18:49 24 A. Yes. Sometimes we'll refer that as the  
11:18:52 25 patient's baseline, or as their cognitive reserve,

11:18:55 1 so their ability to compensate for these cognitive  
11:18:58 2 issues.

11:18:59 3 Q. And how do you estimate the cognitive reserves  
11:19:03 4 of Mr. Brockman?

11:19:04 5 A. I think by all indications, Mr. Brockman is a  
11:19:06 6 person of superior intelligence. He's been very  
11:19:09 7 successful in running his company.

11:19:11 8 Q. How does that help inform your view of the  
11:19:14 9 FDG-PET images?

11:19:16 10 A. Well, all other things being equal, you would  
11:19:19 11 expect again someone who is at a higher level of  
11:19:21 12 intelligence to be able to compensate for those  
11:19:25 13 problems more than the average person.

11:19:26 14 Q. Actually, I realized I -- I missed -- I skipped  
11:19:29 15 something. There are more than one types of PET  
11:19:32 16 scans in this case; isn't that right?

11:19:34 17 A. There are, yes. So we've been referring to the  
11:19:37 18 FDG-PET that looks at metabolism or the brain  
11:19:40 19 activity, and that looks at brain damage. The other  
11:19:43 20 PET scan that was obtained in this case is the  
11:19:46 21 amyloid PET scan. So rather than binding to glucose  
11:19:50 22 in the body, it binds to amyloid, and that test for  
11:19:53 23 that first biological protein associated with  
11:19:56 24 Alzheimer's disease.

11:20:00 25 Q. Without saying the word that FDG stands for --

11:20:05 1 we want to be on the court reporter's good side --  
11:20:07 2 what does the FDG mean in FDG-PET; what is that  
11:20:10 3 referring to?

11:20:11 4 **A.** So it refers to binding to glucose or sugar.  
11:20:14 5 So it is essentially the energy source for the  
11:20:19 6 brain, and how much of that glucose is going to  
11:20:22 7 certain parts of the brain indicates how active  
11:20:24 8 those brain areas are.

11:20:29 9 THE COURT: Counsel, we're going to  
11:20:30 10 take our break at this time. About every hour and a  
11:20:33 11 half we'll be taking a break. So we'll take a break  
11:20:36 12 at this time for ten minutes, and then we'll start  
11:20:38 13 at 11:30 and push through to lunchtime.  
11:20:53 14 (Whereupon, a recess was held.)

11:41:24 15 Counsel, you may continue when ready.

11:41:28 16 MR. MAGNANI: Thank you, Your Honor.

11:41:31 17 **Q.** Dr. Darby, we left off talking about imaging  
11:41:33 18 and you were describing the FDG-PET. Were any  
11:41:37 19 FDG-PETs done of Mr. Brockman's brain?

11:41:40 20 **A.** Yes, Mr. Brockman had two FDG-PETs done. So,  
11:41:44 21 he had the first one done in March of 2021, and then  
11:41:47 22 he had a second FDG-PET performed in August of 2021.

11:41:52 23 **Q.** And who asked for these FDG-PET scans to be  
11:41:57 24 done?

11:41:58 25 **A.** So they were -- it was me that asked for the

11:42:00 1 FDG-PET scans, and I assisted to order the first one  
11:42:04 2 in March. I believe the recommendation for the  
11:42:06 3 second one was communicated that it wasn't actually  
11:42:10 4 ordered by me in August.

11:42:11 5 Q. But is it the case that you recommended  
11:42:13 6 ordering both of these scans?

11:42:14 7 A. Yes, I did. I thought it would be helpful in  
11:42:17 8 this case.

11:42:18 9 Q. Okay. Were --

11:42:21 10 MR. MAGNANI: And this is a  
11:42:22 11 pre-admitted exhibit, Your Honor.

11:42:25 12 Q. Dr. Darby, can you please -- there's some  
11:42:26 13 binders behind you. Can you please flip to  
11:42:29 14 Exhibit 43, and just tell the Court what those are?

11:42:49 15 You know, Dr. Darby, are they on the  
11:42:52 16 screen in front of you?

11:42:54 17 A. Yes, they are.

11:42:54 18 Q. Okay. So what is Exhibit 43?

11:42:57 19 A. So these are the FDG-PET scan reports from  
11:43:01 20 Houston Methodist Hospital.

11:43:04 21 Q. Is there a part of the report written in  
11:43:06 22 English that anyone can understand?

11:43:08 23 A. Yes, the impression section gives the overall  
11:43:16 24 impression of the radiologist.

11:43:17 25 Q. Let me ask you a different question. When you

11:43:19 1 say the radiologist, who are you talking about?

11:43:23 2 **A.** So this is the clinical radiologist working at  
11:43:25 3 Houston Methodist Hospital. So normally a  
11:43:28 4 radiologist would be the person reviewing the images  
11:43:30 5 and interpreting them.

11:43:32 6 **Q.** So what are the impressions of that  
11:43:36 7 radiologist?

11:43:37 8 **A.** So the impression of that radiologist from the  
11:43:40 9 March 2021 FDG-PET are that, "The findings are very  
11:43:45 10 mild, but suggestive of early neurodegenerative  
11:43:48 11 disease, either Alzheimer's disease or dementia with  
11:43:51 12 Lewy bodies, in parentheses Parkinson's disease with  
11:43:53 13 dementia.

11:43:55 14 "Findings unlikely to represent  
11:43:57 15 frontotemporal dementia."

11:44:06 16 **Q.** Can you go to the last page of the exhibit,  
11:44:08 17 Mr. Bourget?

11:44:09 18 What's this one, Dr. Darby?

11:44:10 19 **A.** So this is the FDG-PET scan report from August  
11:44:14 20 of 2021.

11:44:15 21 **Q.** And so, what -- and who was the interpreting  
11:44:18 22 radiologist in this case?

11:44:19 23 **A.** Again, it was the clinical radiologist at  
11:44:22 24 Houston Methodist Hospital.

11:44:23 25 **Q.** What were the impressions for this second

11:44:26 1 FDG-PET?

11:44:27 2 **A.** And so, the findings -- the impression were  
11:44:30 3 that, "The findings are mild, but very suggestive of  
11:44:35 4 neurodegenerative disease, particularly Alzheimer's  
11:44:38 5 disease, although statistically less likely dementia  
11:44:39 6 with Lewy bodies or Parkinson's disease with  
11:44:41 7 dementia can have a similar scan pattern. The  
11:44:44 8 markedly abnormal uptake and prior PET scan also  
11:44:48 9 somewhat favors Alzheimer's disease over DLB/PDD."

11:44:52 10 **Q.** Ask you to break out those initialisms. So  
11:44:56 11 what's PDD?

11:44:57 12 **A.** So PDD is Parkinson's disease dementia. DLB is  
11:45:02 13 dementia with Lewy bodies.

11:45:04 14 **Q.** Do you agree with the findings of this  
11:45:07 15 radiologist?

11:45:09 16 **A.** Yes, I largely agree with these findings that  
11:45:11 17 they show abnormalities that are mild, but are  
11:45:14 18 suggestive of the diseases mentioned.

11:45:16 19 **Q.** And did you have the opportunity to read  
11:45:18 20 Defense expert reports that also interpret these  
11:45:21 21 images?

11:45:21 22 **A.** I did, yes.

11:45:23 23 **Q.** Did you have the opportunity to read Dr. Maria  
11:45:26 24 Ponisio's report that also interprets these images?

11:45:29 25 **A.** Yes, and I have a graph that represents the

11:45:32 1 different opinions in this case regarding the PET  
11:45:34 2 scan.

11:45:42 3 MR. MAGNANI: Apologize, Your Honor.  
11:45:43 4 Just bringing this up now.

11:45:46 5 Q. While we're doing that, Dr. Darby, can you just  
11:45:48 6 sort of describe what, if any, are the disagreements  
11:45:50 7 between the different interpreting doctors?

11:45:52 8 A. Yes. And so -- so as it's up here, there are  
11:45:56 9 three main things that we're looking for in the PET  
11:45:59 10 scan. So one is the pattern of where we're seeing  
11:46:03 11 abnormalities. So what's the pattern of the damage?  
11:46:06 12 Does that match the diseases that we're interested  
11:46:10 13 in knowing about?

11:46:11 14 So in regards to that pattern,  
11:46:13 15 there's largely agreement across the different  
11:46:15 16 experts. So this graph shows the clinical  
11:46:18 17 radiologist, Dr. Ponisio's opinion, who is the  
11:46:22 18 nuclear radiologist hired by the Government;  
11:46:25 19 Dr. Whitlow's interpretation as Defense expert; and  
11:46:28 20 my own impressions.

11:46:29 21 We essentially all agree these  
11:46:32 22 findings could be in a pattern one could see in  
11:46:34 23 Alzheimer's disease or the Parkinson's disease with  
11:46:36 24 cognitive impairment.

11:46:41 25 Q. And what are -- what about the severity of the

11:46:43 1 disease; is there agreement on that?

11:46:45 2 **A.** There's largely agreement in the severity as  
11:46:48 3 well. And so the clinical radiologist described  
11:46:51 4 these changes as mild. Dr. Ponisio described them  
11:46:54 5 as early Alzheimer's dementia. I agree that they  
11:46:59 6 look mild.

11:47:01 7 Dr. Whitlow did not comment on the  
11:47:03 8 severity regarding the August PET scan. He did say  
11:47:05 9 that it looked similar to the March 2021 PET scan,  
11:47:09 10 at which time he agreed with the clinical  
11:47:11 11 radiologist that the findings were mild.

11:47:13 12 **Q.** And so, what are the disagreements, if any,  
11:47:16 13 between the experts?

11:47:18 14 **A.** And so, the major disagreement is with the  
11:47:21 15 clinical correlation. So this is what I do as a  
11:47:24 16 neurologist is I evaluate the patient and relate  
11:47:28 17 symptoms and the severity to the information from  
11:47:29 18 the PET scan and see do those correspond with each  
11:47:35 19 other. This is where Dr. Whitlow stated he felt  
11:47:40 20 these findings were consistent with the demonstrated  
11:47:40 21 dementia and the neuropsychological testing, and I  
11:47:43 22 disagree with that.

11:47:44 23 So the findings are showing mild  
11:47:46 24 changes in terms of the severity that are far  
11:47:48 25 different than the severe -- moderate to severe

11:47:52 1 dementia symptoms that Mr. Brockman is presenting  
11:47:54 2 with. So I there's a disconnect there.

11:47:56 3 Q. And so, is that disconnect -- is it related to  
11:48:01 4 the proportionality of these -- of the different  
11:48:04 5 signs that you are seeing? How would you describe  
11:48:06 6 that disconnect?

11:48:07 7 A. It is. So as these diseases progress over  
11:48:10 8 time, the amount of brain damage increases. So it  
11:48:13 9 spreads to new areas of the brain, and that's what  
11:48:16 10 leads to the clinical progression. So as more and  
11:48:19 11 more damage occurs, there are more and more  
11:48:21 12 symptoms.

11:48:22 13 So we're trying to make that  
11:48:23 14 correspondence between the amount of brain damage  
11:48:25 15 and the clinical symptoms. And that is where I  
11:48:27 16 think the disconnect is.

11:48:28 17 Q. And so you said that the images everyone agrees  
11:48:30 18 are mild, but how do you estimate the -- what you  
11:48:35 19 are describing as clinical symptoms or clinical  
11:48:37 20 presentation?

11:48:38 21 A. So that's based on my review of the records of  
11:48:41 22 the reports that Mr. Brockman and his wife and  
11:48:43 23 others are giving regarding his functional  
11:48:46 24 impairments with the neurocognitive testing results  
11:48:48 25 where he's scoring at low levels, really, taking all

11:48:53 1 of those clinical observations regarding the  
11:48:54 2 severity of the problems that he's demonstrating and  
11:48:57 3 comparing that to the imaging findings.

11:48:59 4 Q. In your clinical practice -- I guess or your  
11:49:04 5 research, do you ever have occasion to compare  
11:49:06 6 images to what you see in a clinic?

11:49:09 7 MR. LOONAM: Objection. Compound.

11:49:12 8 MR. MAGNANI: We can take it one at a  
11:49:13 9 time, Dr. Darby.

11:49:16 10 THE COURT: One second. Okay. Just  
11:49:18 11 break it up. That'll be fine.

11:49:20 12 MR. MAGNANI:

11:49:20 13 Q. In your clinical practice, do you ever have the  
11:49:23 14 occasion to see patients in person and compare their  
11:49:25 15 presentation with images?

11:49:27 16 A. Yes, so essentially every patient that I  
11:49:30 17 evaluate in clinic, if there's a concern for  
11:49:32 18 cognitive progress, I'm going to order neuroimaging.  
11:49:35 19 And so I relate the neuroimaging findings to the  
11:49:42 20 patient in every case.

11:49:43 21 Q. Do you ever in your research compare what  
11:49:45 22 patients are showing in an exam room with images?

11:49:48 23 A. Yes, so my research also deals with taking  
11:49:51 24 brain imaging findings, and relating that to the  
11:49:53 25 patient's symptoms and their severity.

11:49:55 1 Q. And so, how would you describe the relationship  
11:49:58 2 between the symptoms Mr. Brockman shows in the exam  
11:50:01 3 room and the imaging in this case?

11:50:04 4 A. They're clearly out of proportion. So the  
11:50:06 5 imaging findings on the FDG-PET scan are again at a  
11:50:10 6 mild stage of severity. So there is brain damage,  
11:50:12 7 but it's at the mild stage.

11:50:14 8                       Whereas, he's presenting with very  
11:50:17 9 significant and severe problems. And one might  
11:50:20 10 expect that given his level of intelligence, he  
11:50:22 11 would be able to compensate more than the average  
11:50:25 12 person. So I think there's a disagreement between  
11:50:27 13 the imaging findings, which are mild, and his  
11:50:30 14 clinical symptoms, which are now severe.

11:50:33 15 Q. Dr. Darby, I'd like to point you, under the  
11:50:36 16 Dr. Ponisio section of your slide it says, "Early  
11:50:41 17 Alzheimer's dementia."

11:50:43 18                       Is early -- well, is that oxymoron?

11:50:47 19 A. I don't know exactly what Dr. Ponisio meant  
11:50:51 20 when she was writing this, but there is often  
11:50:54 21 confusion in the terminology between Alzheimer's  
11:50:56 22 disease and Alzheimer's dementia.

11:51:00 23                       Before we didn't have these ways of  
11:51:02 24 evaluating for brain damage or amyloid, and  
11:51:06 25 Alzheimer's disease was Alzheimer's dementia. But

11:51:09 1 now we have other ways of evaluating to show those  
11:51:12 2 signs earlier and earlier.

11:51:14 3 I would still interpret as finding  
11:51:17 4 of early abnormality.

11:51:19 5 Q. Is that to say in the past you couldn't detect  
11:51:22 6 Alzheimer's disease without seeing the dementia?

11:51:24 7 A. Correct.

11:51:25 8 Q. But now that we can measure amyloid, you can  
11:51:28 9 see the disease before the dementia?

11:51:29 10 A. We know the disease process starts earlier and  
11:51:32 11 that we can -- the amyloid PET scan and other PET  
11:51:36 12 scans can detect signs of brain damage earlier as  
11:51:39 13 well.

11:51:39 14 Q. Now, you know, you mentioned in your practice  
11:51:43 15 in your research you often compare clinical  
11:51:46 16 presentation with neuroradiological images. Did you  
11:51:50 17 do that in this case?

11:51:51 18 A. I did, yes. I compared the severity of the  
11:51:55 19 findings in the FDG-PET with the severity of his  
11:51:58 20 actual symptoms.

11:51:59 21 Q. And so, before getting to the next slide let me  
11:52:04 22 just ask you. When you -- do you have a sense from  
11:52:06 23 seeing your own patients of what dementia, FDG-PET  
11:52:10 24 looks like?

11:52:11 25 A. Yes, so I have, you know, an image in my mind

11:52:14 1 of what the typical Alzheimer's dementia patient --  
11:52:17 2 what their FDG-PET would look like, and similarly  
11:52:20 3 for some of the other disorders being described.

11:52:22 4 Q. And has literature and research on this subject  
11:52:26 5 provided representative exemplars of what those  
11:52:30 6 scans look like?

11:52:31 7 A. Yes, so there are a number of research studies  
11:52:34 8 that have looked at groups of patients with  
11:52:37 9 Alzheimer's disease or other types of dementias, and  
11:52:40 10 shown the areas of abnormality that they have on  
11:52:43 11 their PET scans at the group level -- so kind of  
11:52:47 12 average Alzheimer's disease patient, and looks  
11:52:50 13 similar to my own mental image of what that looks  
11:52:53 14 like.

11:52:53 15 Q. Can we go to the next slide, please?

11:52:58 16 Dr. Darby, did you make a PowerPoint  
11:52:59 17 presentation for this case?

11:53:00 18 A. I did, yes.

11:53:01 19 Q. Okay. Now, this looks a little different than  
11:53:03 20 the slide you created; right?

11:53:04 21 A. Yes.

11:53:05 22 MR. LOONAM: Your Honor, I object on  
11:53:08 23 the basis that the witness is now testifying as to  
11:53:13 24 his opinion and a new basis for the opinion. He's  
11:53:17 25 removed the slides. He's removed the citation, but

11:53:20 1 the substance is exactly the same that, um, he is  
11:53:25 2 sharing a new basis for opinion that was not  
11:53:28 3 disclosed for which I now can't cross him because it  
11:53:30 4 was disclosed last night, so I object.

11:53:33 5 THE COURT: Okay. So this scan --  
11:53:37 6 everybody's seen this scan; right?

11:53:39 7 MR. LOONAM: I don't object to this  
11:53:40 8 scan, Your Honor. What I object to is Dr. Darby is  
11:53:44 9 now saying this scan -- "I am comparing this scan to  
11:53:49 10 these images that were up there, but now we've taken  
11:53:52 11 them down, but I'm still going to testify about the  
11:53:53 12 images that were up there that weren't disclosed to  
11:53:56 13 the Defense, and tell you how they compare to one  
11:53:58 14 another based on my memory of what they looked  
11:54:00 15 like."

11:54:01 16 I can't cross on that.

11:54:02 17 THE COURT: Okay. But I didn't hear --  
11:54:03 18 that was only one of the things he said. He also  
11:54:06 19 said that based on his experience and training  
11:54:09 20 looking at these types of -- this type of injury  
11:54:14 21 that this is the pattern he would expect to see in  
11:54:20 22 -- in a patient that's presenting like Mr. Brockman.

11:54:26 23 MR. LOONAM: My objection, Your Honor,  
11:54:27 24 goes to the comparison of the -- what would be up  
11:54:30 25 there and with the citation and -- and -- and what

11:54:34 1 Dr. Darby I believe was just testifying to -- to --  
11:54:38 2 to what we don't object to.

11:54:40 3 That comparison is what hasn't been  
11:54:42 4 disclosed and the basis of which I -- I don't have.  
11:54:45 5 And so -- so that I object to. If it's -- based on  
11:54:49 6 my experience, I'm looking at these brains and I see  
11:54:51 7 that it's not what I would expect, that's different.  
11:54:54 8 So -- so I agree with Your Honor.

11:54:55 9 THE COURT: Okay. So re-ask the  
11:54:59 10 question, and then I'll see whether or not to  
11:55:01 11 sustain Mr. Loonam's objection.

11:55:06 12 MR. MAGNANI:

11:55:06 13 Q. You testified that you -- well, first, what are  
11:55:10 14 we looking at on this screen, Dr. Darby?

11:55:12 15 A. In the bottom we're looking at images of  
11:55:15 16 Mr. Brockman's brain FDG-PET scan. So this is an  
11:55:20 17 image where his levels of blood sugar in these areas  
11:55:24 18 of the brain has been compared to a group of  
11:55:27 19 patients of similar age where they're not having any  
11:55:31 20 cognitive problems.

11:55:31 21 THE COURT: That's objectionable. I  
11:55:33 22 get it, Mr. Loonam.

11:55:35 23 MR. LOONAM: Thank you, Your Honor.  
11:55:35 24 Yeah.

11:55:36 25 THE COURT: That objection will be

11:55:36 1 sustained.

11:55:37 2                   You can testify -- you can ask the  
11:55:39 3 witness to testify about what he sees in that image  
11:55:41 4 and how it's consistent or not consistent with the  
11:55:44 5 types of diseases that he's testifying about, but he  
11:55:46 6 can't compare what he's seeing to the slides that  
11:55:51 7 aren't there, basically.

11:55:54 8                   THE WITNESS: Is it okay if I make a  
11:55:56 9 comment?

11:55:56 10                  THE COURT: Oh, yes, sir.

11:55:57 11                  THE WITNESS: So I wasn't comparing it  
11:55:58 12 to slides that aren't there. This is actually how  
11:56:01 13 the image was generated.

11:56:02 14                  THE COURT: That's what I thought.  
11:56:04 15 That's why I was going to allow to you testify to  
11:56:05 16 that.

11:56:06 17                  THE WITNESS: Sorry.

11:56:06 18                  THE COURT: No, no, no. No problem.  
11:56:08 19 Please, ask questions.

11:56:15 20                  MR. MAGNANI:

11:56:15 21 Q. I think we can move to the next slide now.

11:56:18 22                   Dr. Darby. As we're doing that,  
11:56:19 23 besides this FDG-PET, you mentioned another type of  
11:56:23 24 brain study that was conducted. Can you tell us  
11:56:26 25 about that one?

11:56:27 1 **A.** Yes, so Mr. Brockman also had a brain MRI scan.  
11:56:31 2 And so again, that's looking at the size of his  
11:56:33 3 different brain areas. So how large they are. That  
11:56:38 4 scan was ordered and was performed in July of 2021,  
11:56:43 5 so July of this year.

11:56:45 6 In addition to having the  
11:56:46 7 radiologist look at it, that scan was sent for  
11:56:50 8 quantitative analysis. So what that means is that  
11:56:53 9 is Mr. Brockman's brain volumes were compared to a  
11:56:57 10 group of subjects who were his same age, but don't  
11:56:59 11 have any neurological problems. They don't have  
11:57:03 12 dementia. They don't have cognitive impairment. So  
11:57:05 13 what we're really trying to determine is does Mr.  
11:57:08 14 Brockman have a lower brain volume in those areas  
11:57:10 15 that might go along with having brain damage.

11:57:13 16 And so, in these graphs we see from  
11:57:16 17 the output of the Neuroreader® report, that  
11:57:20 18 quantitative analysis, how large Mr. Brockman's  
11:57:24 19 brain areas are. And so, it's a number of different  
11:57:26 20 areas in the brain. The black dot is actually  
11:57:30 21 Mr. Brockman's brain volume, so where he falls on  
11:57:32 22 there.

11:57:33 23 On the side of the graph, you see  
11:57:34 24 the percentile that it falls in, so the percentile  
11:57:38 25 of patients or subjects who are same age, 80 years

11:57:42 1 old, but do not have dementia, do not have cognitive  
11:57:46 2 impairment.

11:57:46 3 And we can see that Mr. Brockman's  
11:57:49 4 brain volumes fall within the normal range of what  
11:57:52 5 we expect to see. The lowest brain volume that was  
11:57:55 6 reported was in the temporal lobe, and that was at a  
11:58:00 7 percentile of 23.8 percent, so approximately the  
11:58:03 8 25th percentile. That's typically considered to be  
11:58:07 9 in the normal range.

11:58:08 10 So as an example, the adult male  
11:58:11 11 height at the 25th percentile would be  
11:58:16 12 five-foot-seven. That's my height. For the most  
11:58:18 13 part, we wouldn't consider that to be abnormal.

11:58:22 14 Q. And just to break that down, this is a  
11:58:25 15 volumetric analysis of the volume of Mr. Brockman's  
11:58:28 16 brain?

11:58:28 17 A. Correct. So it is the volumes of different  
11:58:30 18 areas of Mr. Brockman's brain.

11:58:32 19 Q. Is this -- are these percentiles -- does this  
11:58:36 20 compare Mr. Brockman to all 80-year-olds, or just  
11:58:39 21 healthy 80-year-olds?

11:58:40 22 A. No, it's specifically to healthy 80-year-olds  
11:58:45 23 without neurological or cognitive impairments.

11:58:47 24 Q. So how does Mr. Brockman's, from a volumetric  
11:58:50 25 standpoint stand up with normal, healthy

11:58:54 1 80-year-olds?

11:58:54 2 **A.** This shows that he's in the normal range on all  
11:58:57 3 of the brain volumes depicted here.

11:59:04 4 **Q.** We can look at the dot, but you mentioned  
11:59:07 5 23.8 percent being the lowest area. Can you just  
11:59:11 6 describe what his -- what his percentile is in the  
11:59:14 7 other areas of the brain?

11:59:15 8 **A.** Yes, so the other areas in the occipital lobe  
11:59:18 9 is close to the 50th percentile. The front lobe is  
11:59:22 10 about the 30th percentile. The hippocampus --  
11:59:26 11 another area important for memory -- is about in the  
11:59:29 12 45th percentile.

11:59:30 13 **Q.** So what do the other experts say about this  
11:59:35 14 Neuroreader® analysis of the MRI study?

11:59:39 15 **A.** So again, I have a slide comparing the  
11:59:42 16 different impressions and interpretations. And so,  
11:59:45 17 we have both the qualitative interpretation from the  
11:59:49 18 clinical radiologist showing volume loss. I think  
11:59:53 19 the question is that related to his age, or is that  
11:59:56 20 related to an underlying disease?

11:59:59 21 And that's where the quantitative  
12:00:01 22 MRI is helpful in saying that that falls in the  
12:00:03 23 23.8 percentile, for instance, in the temporal lobe.  
12:00:07 24 I don't think there's any disagreement in that  
12:00:09 25 number, but there is disagreement in the

12:00:11 1 interpretation of that.

12:00:12 2 So Dr. Whitlow stated this brain  
12:00:15 3 volume loss is profound in the temporal lobes, and I  
12:00:17 4 would disagree. So that brain volume falls within  
12:00:20 5 the normal range, and is not significantly different  
12:00:22 6 than the population of 80-year-olds without  
12:00:25 7 cognitive problems.

12:00:27 8 I think the second area of  
12:00:29 9 disagreement is again on that clinical correlation.  
12:00:32 10 So how does the brain imaging findings -- how do  
12:00:35 11 those relate to his actual symptoms? Dr. Whitlow  
12:00:38 12 mentioned in his reports that it was beyond what  
12:00:40 13 would be expected for mild cognitive impairment, and  
12:00:43 14 that it explained the significant findings noted in  
12:00:45 15 the clinical interviewing and the psychological  
12:00:48 16 testing.

12:00:48 17 And I would disagree with those  
12:00:50 18 statements. So I do not believe that being at the  
12:00:53 19 23.8th percentile would be evidence of significant  
12:00:57 20 disease, and it does not explain the severe problems  
12:01:01 21 he's now experiencing.

12:01:02 22 Q. And I just -- just to not be confusing, when  
12:01:04 23 you say to be at the 23.8th percentile, you are  
12:01:08 24 talking about cognitively healthy people?

12:01:11 25 A. Correct.

12:01:17 1 Q. So -- okay. I'd like to move on to the Amyvid  
12:01:29 2 or amyloid PET scan.

12:01:30 3 THE COURT: Counsel, I wanted to make  
12:01:31 4 clear with respect to my ruling, with the slide  
12:01:33 5 showing the different scans of the brain I'm not  
12:01:38 6 preventing the witness from being able to testify  
12:01:41 7 about what he sees in Mr. Brockman's scan, and what  
12:01:43 8 that tells him about what's going on. I'm just  
12:01:47 9 ruling that he can't compare it to the two slides  
12:01:49 10 that were before -- that were previously on the  
12:01:52 11 slide.

12:01:53 12 So if he wants to testify about  
12:01:55 13 what he is seeing and how it relates to what he  
12:01:58 14 expects the symptoms to be or functionality to be,  
12:02:03 15 that's fine. He just can't compare it to what was  
12:02:06 16 previously on the slide, just so that you are clear.

12:02:09 17 MR. MAGNANI: I think I understand the  
12:02:11 18 boundaries. I apologize if I overstepped them. I  
12:02:14 19 think the witness testified, and I want to make sure  
12:02:15 20 this is in bounds, is that he has own sort of gut  
12:02:19 21 sense looking at patients, but also there's a body  
12:02:21 22 of other images out there that other people write  
12:02:24 23 academic research papers in.

12:02:26 24 So to sort of confirm that it's not  
12:02:28 25 just his bias, he did compare it. So it's my

12:02:31 1 understanding he can talk about that, but that we  
12:02:33 2 can't show images from that literature.

12:02:35 3 THE COURT: That's perfect. I wanted  
12:02:36 4 to make sure that you understood. You haven't  
12:02:38 5 crossed a line at all. I just wanted to make sure  
12:02:40 6 that you understood that I'm not stopping you from  
12:02:42 7 doing that.

12:02:43 8 MR. MAGNANI: Okay.

12:02:44 9 MR. LOONAM: I just want to clarify. I  
12:02:45 10 don't object to part one, right, of talking about,  
12:02:50 11 "I'm looking at these images, and based on training  
12:02:53 12 and experience this is what I would see and what I  
12:02:55 13 would expect."

12:02:56 14 I do -- my objection does include  
12:02:58 15 talking about part two, which is I looked at  
12:03:02 16 research, um, and -- and this is what I would expect  
12:03:05 17 from the research and this is what I would see.

12:03:11 18 THE COURT: Second part only comes into  
12:03:13 19 play based on cross-examination if you get into  
12:03:15 20 challenging his viewpoint as to what he's seeing and  
12:03:19 21 said that it's not supported, then you probably will  
12:03:21 22 open the door up to those other two slides. So I  
12:03:24 23 have to wait to see what -- what the  
12:03:27 24 cross-examination is.

12:03:29 25 MR. LOONAM: Okay.

12:03:30 1 THE COURT: So you may continue.

12:03:31 2 MR. MAGNANI: Sorry on the second part,  
12:03:35 3 I understand Defense Counsel has an objection, but  
12:03:37 4 I'm not -- frankly, Your Honor, I think we're beyond  
12:03:39 5 that, and I don't think I need to talk about this  
12:03:42 6 anymore. I think the record's been --

12:03:48 7 And so -- okay.

12:03:50 8 Q. And so, Dr. Darby, I wanted to move on to that  
12:03:55 9 other kind of PET scan you were talking about, which  
12:03:57 10 is the amyloid PET scan. Again, can you sort of --  
12:04:01 11 I know you talked about positive amyloid before, but  
12:04:04 12 can you help us all understand is there any  
12:04:06 13 disagreement on what this PET scan reveals?

12:04:09 14 A. No. So I think everyone who has looked at it  
12:04:12 15 agrees that it's a positive amyloid scan -- positive  
12:04:15 16 for amyloid in the brain. I think that everyone  
12:04:18 17 largely agrees with what that means. It's the first  
12:04:21 18 biological process that occurs in Alzheimer's  
12:04:23 19 disease.

12:04:23 20 It's necessary, but not sufficient,  
12:04:25 21 if are the diagnosis and that it doesn't correspond  
12:04:29 22 to the degree of cognitive impairment.

12:04:34 23 Q. You said it was the first -- I don't know --  
12:04:36 24 did the first biological change, the first protein  
12:04:40 25 we see accumulated, but what's the second one?

12:04:42 1 **A.** So the second one is tau. So the tau and the  
12:04:45 2 deposition of tau is what seems to correspond more  
12:04:49 3 closely to the brain damage and subsequent clinical  
12:04:52 4 symptoms.

12:04:53 5 **Q.** And were you able to interpret the level of  
12:04:56 6 accumulation of tau, if any, in Mr. Brockman's  
12:04:58 7 brain?

12:04:59 8 **A.** No, there's no tau testing done in this case.  
12:05:02 9 So it is possible to test for tau in the spinal  
12:05:04 10 fluid, and there are tau PET scans similar to the  
12:05:08 11 amyloid PET scan that can be obtained.

12:05:11 12 **Q.** So what -- you know, we're talking about this  
12:05:13 13 in the context of Alzheimer's. You know, why does  
12:05:15 14 it matter whether or not Mr. Brockman has  
12:05:18 15 Alzheimer's?

12:05:20 16 **A.** I think for the current purposes it doesn't.  
12:05:23 17 So what we really care about is the level of his  
12:05:26 18 cognitive impairment. That's most directly  
12:05:29 19 corresponding to the level of brain damage.

12:05:31 20 So whether that's due to  
12:05:33 21 Alzheimer's disease or Parkinson's, it's really that  
12:05:37 22 amount of brain damage and the severity of the  
12:05:40 23 cognitive symptoms that it's resulting in that's  
12:05:43 24 important.

12:05:44 25 **Q.** Okay. We've talked about a lot of different

12:05:47 1 types of brain studies that were done in this case.

12:05:49 2 Can you advance the in next slide, please and tell

12:05:55 3 us what do these brain studies reveal?

12:05:57 4 **A.** So this is just a summary of what we've been

12:06:00 5 talking about. So first the FDG-PET scan shows mild

12:06:05 6 brain damage, so mild neurodegeneration.

12:06:09 7 This is really consistent with the

12:06:12 8 mild cognitive impairment stage, or possibly the

12:06:15 9 mild dementia stage. The brain MRI does not show

12:06:18 10 any clear abnormalities, so the brain volumes from

12:06:20 11 the MRI scan are within the normal range of what we

12:06:25 12 expect from healthy, non-cognitively impaired

12:06:32 13 80-year-olds.

12:06:32 14 And the third thing is that the

12:06:32 15 amyloid PET scan was positive. So again it shows

12:06:33 16 that first biological change in Alzheimer's, which

12:06:36 17 is necessary but not sufficient. So we don't have

12:06:38 18 the information on the second biological change.

12:06:42 19 Um, and the amyloid itself does not correspond with

12:06:45 20 the degree of cognitive impairment.

12:06:48 21 So someone may be cognitively

12:06:50 22 normal with a positive amyloid scan, versus a severe

12:06:53 23 dementia patient with an amyloid scan and wouldn't

12:06:55 24 be able to likely tell the difference.

12:06:57 25 **Q.** And so, just on that MRI I understand you are

12:06:59 1 saying it's normal compared to cognitively normal  
12:07:04 2 80-year-olds. In your work -- break it down. In  
12:07:07 3 your work, what do the MRI's look like with patients  
12:07:14 4 of mild to moderate or severe dementia?

12:07:17 5 **A.** When patients progress to mild or moderate  
12:07:20 6 severe dementia, there are typically findings on the  
12:07:23 7 MRI scan that go along with that. So the PET scan  
12:07:25 8 is more sensitive, so earlier on in the disease  
12:07:27 9 course that can be more present.

12:07:28 10 As patients progress, there is more  
12:07:30 11 and more evidence of neurodegeneration or volume  
12:07:34 12 loss on the brain MRI's. Certain areas like the  
12:07:37 13 hippocampus where we look for in Alzheimer's  
12:07:40 14 disease, typically older patients with Alzheimer's  
12:07:43 15 disease as they advance would show changes.

12:07:47 16 **Q.** Okay. So you -- you mentioned how the imaging  
12:07:53 17 we're all looking at forms your opinion. Can you  
12:07:57 18 talk about how the natural course of these diseases  
12:08:00 19 also forms your opinion? You mentioned that  
12:08:02 20 earlier.

12:08:03 21 **A.** Yes, so I -- when I evaluated Mr. Brockman in  
12:08:06 22 May of 2021, I diagnosed him at the level of mild  
12:08:11 23 cognitive impairment. These are diseases that do  
12:08:13 24 progress over time. That change happens over a  
12:08:18 25 number of years. So in general, from the time of

12:08:21 1 diagnosis of dementia to death that would be on the  
12:08:24 2 order of five to ten years.

12:08:25 3 In patients with mild cognitive  
12:08:28 4 impairment, there is some rate of progression to  
12:08:30 5 dementia over a year that might be -- as a ballpark  
12:08:35 6 15/20 percent.

12:08:38 7 Q. And I'm sorry, just to -- so moving from MCI or  
12:08:43 8 mild cognitive impairment to dementia, you're saying  
12:08:47 9 there's a 15 percent chance per year of that  
12:08:49 10 happening?

12:08:50 11 A. Approximately, yes.

12:08:50 12 Q. To dementia to death is about five to ten  
12:08:53 13 years?

12:08:53 14 A. Five to ten years is a good, rough estimate.

12:08:56 15 Q. Okay. So -- sorry, you were saying you  
12:08:59 16 diagnosed him with MCI in May. So taking that, what  
12:09:02 17 does the natural disease course tell us?

12:09:05 18 A. So from May to now, over the course of six  
12:09:07 19 months, I would expect that there could be some mild  
12:09:11 20 progression changes. I would expect him to have a  
12:09:14 21 little bit more trouble with the things he was  
12:09:16 22 having trouble with before, and to likely still be  
12:09:18 23 at the stage of mild cognitive impairment, although  
12:09:21 24 there is that risk he could have progressed to the  
12:09:23 25 stage of mild dementia, absent other extenuating

12:09:28 1 circumstances that could have interfered with that.  
12:09:30 2 Q. So your starting point is May 2021. I know you  
12:09:36 3 wrote two expert reports in this case, so I'm going  
12:09:37 4 to take you back to the first one. What -- what  
12:09:40 5 gives you confidence in your May 2021 diagnosis of  
12:09:46 6 MCI?

12:09:46 7 A. Well, I examined a great deal of evidence from  
12:09:50 8 the initial report. And so, what I looked at were  
12:09:54 9 his videos of depositions and speeches in 2019,  
12:09:58 10 where he appeared to be performing at the normal  
12:10:00 11 range.

12:10:01 12 I looked at his work history. And  
12:10:03 13 so, he continued to work at his job in a leadership  
12:10:09 14 position at Reynolds and Reynolds through the time  
12:10:11 15 he retired in November of 2020.

12:10:14 16 There was deposition testimony  
12:10:16 17 available for me to review from Tommy Barris, the  
12:10:20 18 successor of Mr. Brockman at the company, somebody  
12:10:23 19 who worked very closely with him. He did not note  
12:10:26 20 any significant cognitive problems that he felt  
12:10:29 21 would have interfered with Mr. Brockman's ability to  
12:10:31 22 continue functioning in that high role.

12:10:34 23 I also looked at the medical  
12:10:36 24 records that were available. And so, Mr. Brockman  
12:10:39 25 saw his treating neurologist, Dr. Lai, in February

12:10:43 1 of 2021, at which point he was diagnosed as being in  
12:10:47 2 the MCI stage, mild cognitive impairment stage.

12:10:52 3 There are also medical records from March  
12:10:54 4 hospitalization where he was hospitalized for an  
12:10:56 5 infection and delirium where they noted  
12:11:00 6 Mrs. Brockman stated that he was functionally  
12:11:02 7 independent prior to that time.

12:11:04 8 And then I also based it on my  
12:11:06 9 interview with him and my examination.

12:11:10 10 MR. MAGNANI: Um, and I want to show a  
12:11:12 11 clip from that examination, if I may, Your Honor?

12:11:15 12 THE COURT: Sure.

12:11:16 13 MR. MAGNANI: This is about two and a  
12:11:17 14 half minutes long.

12:11:18 15 THE COURT: Not a problem.

12:11:19 16 MR. MAGNANI: This is Exhibit 40, which  
12:11:21 17 is admitted. I'd like to start the video at  
12:11:25 18 18 minutes and 47 seconds.

12:11:37 19 THE COURT: Counsel, stipulate that --  
12:11:39 20 sorry.

12:11:56 21 (Whereupon, audio played and not reported.)

12:14:22 22 MR. LOONAM: Could we mark for the  
12:14:24 23 record where he stopped?

12:14:25 24 MR. MAGNANI: I was just going to do  
12:14:26 25 that. It's unclear. So this is from Exhibit 40,

12:14:30 1 and it's from 18 minutes and 47 seconds to  
12:14:33 2 21 minutes and 15 seconds. Actually, I just want to  
12:14:36 3 raise now -- actually, what we played was a clip  
12:14:40 4 pulled from that video. So we don't have to fidget.  
12:14:43 5 I hope that's okay.

12:14:45 6 THE COURT: Not a problem. Counsel,  
12:14:46 7 it's 12:15. We have to take our break right now.  
12:14:52 8 So I hate to get you in the middle of a thought, but  
12:14:54 9 hold on and we'll take a recess until 1:15. I have  
12:14:57 10 another matter to handle at 12:45 to about one  
12:15:03 11 o'clock. Don't worry, being in here won't interfere  
12:15:06 12 with that.

12:15:06 13 So if we'd all be back at 1:15, get  
12:15:10 14 started then.

12:15:11 15 MR. VARNADO: Your Honor, okay to leave  
12:15:13 16 our materials?

12:15:14 17 THE COURT: You can leave everything  
12:15:15 18 the way it is.

19 **(WHEREUPON, THE PROCEEDINGS WERE RECESSED AT 12:15**  
20 **P.M.)**

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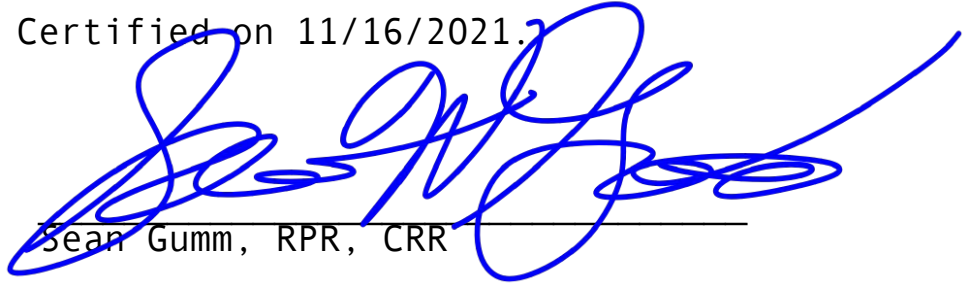
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C E R T I F I C A T E

I hereby certify that pursuant to Title 28,  
Section 753 United States Code, the foregoing is a  
true and correct transcript of the stenographically  
reported proceedings in the above matter.

Certified on 11/16/2021.



Sean Gumm, RPR, CRR

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